## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

state of Maryland / Department of Health Certificate of Death Mental Hygiene

Physician	
/Medical	
Examiner	

1. Decedent's Neme (First, Middle, Last) Unknown 99-209

Reg. No 2. Dete of Death Dev Month SEPTEMBER 9, 1999

4c. County of Deeth

3. Time of Death 1500 PM

**Funeral** Director

filed within 72 hours after

permit. Pages 1 and 2 should be Department of Health and Mental Important: if Nem 27 is marked or

**Physician** -/Medical

Examiner

attending physician and for use as the bunal-transit

ed by the s

signed by t

been si

certificate has

: After this certifical a funeral director, p

death.

thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu

within 2 To the F the

Hospital or Attending Physician: The law requires that the death certificate be assouted

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0020

Baltimore,

r than "natural", or liams 23s or 28s-f show the Medical Examiner must be notified at Director Funeral ģ

8

2

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai

10e. Street end Number 11. Maritel Stetus unknown Completed

214 NORTH AMITY STREET unknown

7. Age (In yrs. last birthday) Yrs. unknown

If Under 1 Yeer If Under 24 Hrs. Months Deys Hours

8. Dete of Birth (Month, Dev. Year) unknown

 Birthplace (State or Foreign Country) unknown

unknown Usual Residence of Decedent 10b. County

5. Social Security Number

unknown unknown

4e Facility Neme (If not institution, give street and number)

unknown

10c. City, Town or Location

10f. Zip Code

unknown

4b. City. Town, or Location of Deeth

BALTIMORE

1 ☐ Yes 2 ☐ No unknown

10d. Inside City Limits

unknown

12. Wes Decedent Ever in U,S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Tyes 2 No Specify:

unknown 14. Race - American Indien, Bleck, White, etc.

10g. Citizen of What Country?

1 Never Merried 2 Married 3 Widowed 4 Divorced

1 Yes 2 No Yeer or Detes: unknown 15. Decedent's Education (Specify only highest grede completed)

unknown 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown 16b. Kind of Business/Industry

unknown

College (1-4or 5+) unknown

unknown

unknown

17. Fether's Neme (First, Middle, Last)

unknown

18. Mother's Neme (First, Middle, Maiden Surneme) unknown

19e. Informent's Neme/Relationship (Type, Print) O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 111 Penn Street, Baltimore, Maryland 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete

20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State

4 □ Donetion 5 ☑ Other (Specify) in state

S. Wade, Director State Anatomy Board 655 W. Baltimore Street

21. Signature of Fune all Service Licensee Ronald

Baltimore, MD 21201

23a. Pirt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es a consequence of):

Due to (or es e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

2 No

24b. Were eutopsy findings aveilable prior to completion of cause of death?

SCENE

26. Plece of Deeth (Check only one)

1 MYes 2□ No

25. Wes case referred to medical exeminer? MXYes 2□ No

27. Menner of Death

6 Could not be determined

26a. Date of Injury (Modifi, Day Year) 5 Pending Investigation

28b. Time of Four Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Bc. Injury et Work? 2 I No 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Subject Assaur.

281. Location Screet and Number or Rural Route Number, City or Town State)

St. Baltwere, Mcl

29a. Certifier (Check only one)

1 Neturel

2 Accident 3 Suicide

4 Homicide

( Found) 214 N. Amity House 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

S

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) SEPTEMBER 10, 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) É

estane, 111 Penn Street, Baltimore, Maryland 21201

State

31. Dete filed (Month) Day, Year) NOV 1 6 1999 32. Registrer's Signeture

DMMH 16 Rev 6/95

**ORIGINAL** 

Registrar

power to sported

WOV 1 6 1999

1. Decedent's Name (First, Middle, Last)

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland /

Department of Health and Mental H	ygiene
Certificate of Death	Reg No

2. Dete of Deeth

3. Time of Death

5:45 PM

1 ☐ Yes 2 ☐ No

Approximate tervel Bet Onset end Deeth

Physician
/Medical
Examiner

**Funeral** 

Director

Director

Funeral

g

Completed

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

by

Be Completed

ဥ

Medical Certification:

ettending physician and for use as the burial-transit ed by the e signed by the After this certificate hes been sit funeral director, page 2 should? To the Hospital or Attanding Physiwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

The law requiras that tha daath certificete be axecuted

Box 68760,

Division of Vital Records, P.O.

Attanding Physician:

Month Unknown AUGUST 21, 1999 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 2100 SOUTH HANOVER STREET BALTIMORE 6. Sex unknownage (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) UNKNOWN 5. Social Security Number 9. Birthplece (State or Foreign Deys 1 M 2 F unknown unknown Yrs. unknown Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits unknown unknown unknown unknown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? unknown unknown unknown 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Unknown 11. Marital Statusunknown Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced unknown 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) unknown unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) O.C.M. E. 111 Penn Street, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Fune) alterrice biconsee. Wade, Director 22. Wana and Add and Early Board 655 W. Baltimore Street Baltimore, Maryland 21201 Pet 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) • PROBABLE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? OAh More outoney findin

		performed? 240. Were europsy informings eveileble prior to completion of cause of deeth?
		XX Yes 2 No XX Yes 2 No
25. Was case referred to medical examiner?	26. Plece of Dee	ith (Check only one)
XXYes 2□ No	Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence XXOther (Specify)AT SCENE
27. Manner of Death  XXXNaturel 2 ☐ Accident  5 ☐ Pending investigation		28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)  1 Certifying Phy XX Medical Exami	sician: To the best of my knowledge, deeth occurred at the time, dete end plece, iner: On the basis of examination end/or investigation, in my opinion, death occur	, end due to the ceuse(s) end menner es steted. rred et the time, date end place, end due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

O.C.M.E.

10-8-99

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MARGARITA A. KORELL, M.D. 31. Date filed (Month, Day, Year)

111 PENN STREET, BALTIMORE, MARYLAND

State Registrar

NOV 1 6 1999



LEST DIVON

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

NDED ITEM #10e	PER FH G777 11/19/99 /	State of Maryla		artment of F			giene 9 Reg. No.	9 36	5003
	1. Decedent's Neme (First, Middle, La	ist)				2. Dete of Dea	ath		Time of Death
Physician /Medical	Alma	Watts	-11			Nov.	Dey	Yeer	::30am
Examiner	4a Facility Name (If not institution, given	re street and number)			b. City, Town, or Lo		4c. County		1 Journ
Manager 11.	Genesis Elder	Care-Homew	ood		Baltimo			IA	
Funeral Director	218-22-4438	Sex 7. Age (In ) 1□ M 2□ F 74	rrs. last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 08-16		9. Birthplace ( Country) MD	(Stete or Foreign
2 *	Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	cation				10d In	side City Limits
with the Maryland a or 28e-f show Libs notified at Director	MD NA		altimor						Yes 2 No
with the Mar a or 28e-f a he notified Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	
The or	LVMEATO	t Apt. B-#	1	2123	4		USA		
after death v or Items 23s miner must	11. Marital Status	12. Wes Decedent Ever in			ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	e - American Inc	dien,
5-0020 72 hours after matural', or its dical Examina sted by Full	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 3 No If Yes, Give Year or Dates:		Tes, specify Cubi		Hican, etc.)	Specify	k, White, etc.  Black	,
Phouse Parkers	15. Decedent's E	ducation	16a. Deced	ient's Usuel Occup	ation		16b. Kind of Bu	usiness/Industry	
215	(Specify only highest gra		(Give	kind of work done  OO NOT use retired	during most of work d)	ing			
d 2121 lied within Hygiene. ther then mr. the Me	Ist. Grade	College (1-4or 5+) NA	Cler	rical			Mercy	Med. C	ltn.
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filled within 72 hours all begardness of Health and Mental Hygiene. Important: If them 27 is marked other than "satural", or my injury or other traumatic event, the Medical Examples.  To Be Completed by F	17. Fether's Neme (First, Middle, Last	)			18. Mother's Name	e (First, Middle.	Maiden Sumem	10)	
yla Menta miles atte	Bernard	Webb			Mildre		Myers		
Aar and a substant	19a. Informant's Neme/Reletionship				and Number or Rur				
Fe, N Feath Hem 27 other 1	Bernard D. Ta				ern Aven				
I To I	20a. Method of Disposition  X□ Burial 2 □ Cremetion 3 □	THOUGH ILOUI 2000		sition (Neme of netory or other plea		Dete	20c. Location -	City or Town, S	tate
Saltime emit. Pag Apartment reportent: It ny injury o	4 Donation 5 Other (Special				emetery	11-15+	99 Ba	ltimor	e, MD
Balt permit. Depart Import any inj ance.	21. Signature of Funeral Service Lice	nsee		Name and Addre	ss of Fecility Barch FH		e, Mar	-	
	23a. Pert1. Enter the disease, or corr shock, or heart failure. List only	plications that caused the d						Appr	roximete vel Between
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	e. Mutash	atic Coorsec					Onso	et end Death
3760, are be axecuted hysician end he burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	o (or es e conseq	uence of):					
00 # FE =	Cause (Disease of Injury that initieted events resulting in death) Last	Due to	o (or as a conseq	uence of):					
Boeth atter	Part II Other significant conditions			dad ten seven et	an in David	non Did		atribute to the	seven of death?
P.O. nat the de de by the setached Physic	DVT	contributing to death but not	ling to death but not resulting in the underlying cause given in Pert I.						cause of deeth?
Cord requir been s should							en eutopsy med?	aveilable	utopsy findings e prior to ion of cause i?
The le ha						101	res 20 No	1 ☐ Yes	30 No
Vital Relationary Interpretation of the law rector, page 2 Be Comp	25. Was case referred to medical				26. Place of Deel	th (Check only o	ne)		
Of V Physiol this can rai direc	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho	ome 5 Resid	dence 6 □Oth	er (Specify)	
On O ding Ph h. After th funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor	y et k? Yes 2 □ No	28d. Describe t	now injury occur	red	11111
Division of Vital Records to the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this cartificate has complately filled in by the funeral director, page 2	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spo	t home, farm, str ecify)	eet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	per or Rural Rou	te Number,
Hospit 24 hour Funera ately fille	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my liner: On the basis of exame and manner steled.	knowledge, death ination and/or inv	occurred at the tir	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) end me date and place,	enner es stated. and due to the o	Deuse(s)
outher of the complete of the	29b. Signature and title of certifier	and man evered.		29c. Licens	e number		29d. Date signe	d (Month, Day,	Year)
1	Manting 1	1 di mon es en el .	110	054	518		11-12.	99	
0	30. Name and eddress of person who	completed cause of death (	Item 23a) (Type,		Balting	2 1117			
State	31. Date filed (Month, Day, Year)  NOV 1 6 1999	32. Registrar's Si	gnature	an L	OUU VIA	1900	1/1/4		
Registrar	MOA T 0 1923	1	~ /4						

HOV 1 6 1939 January 18

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36004

					Ce	rtificate	e of	Death		F	Reg. No.		
		1. Decedant's Nama (First, Middle, I	.ast)							2. Data of Das	ath	V	3. Tima of Death
Physicia		PATRICK 1	JALL	45						Novemb	Day	Yaar	2:33 p
/ /Medica Examine		4a Facility Nama (If not institution, g		-				4b. City, To	own, or L	ocation of Death			
LAdmine	"	BALTIMORE VA	h	sich	LENTET	2_		Pa	The	PE		N/A	
Funeral			Sex		n yrs. last birthday	If Undar		If Undar	24 Hrs.	8. Data of Birt	h Vaar)	9. Birthp	laca (State or Foraig
Director		202-05-9480	1 🖾 M 2□	F	78 Yrs.	Months	Days	Hours	Min.	Sept. 2	, 1921	Coun	Maryland
ס		Usual Rasidence of Decedant											
how how	.	10a. Stata 10b. County		10	oc. City, Town or L.	ocation						1	Od. Inside City Limits
Ma Ma	5	Maryland Balt	imore	Co.	Parkv:	ille							1 ☐ Yas 2 No
death with the Maryland	9	10e. Street and Number				10f. Zip	Coda				10g. Citizan of	What Coun	try?
19 N	a	2807 Upridge C	ourt	Apt. D				2123	4		Uni	ted S	tates
	Funeral Director	11. Marital Status	12. Was	Decedant Eva	r in U,S. 13.	Was Decede	ant of	Hispanic Or	igin? (Sp	ecify Yas or No- Rican, atc.)	14. Rac	e - Amaric	
or ha	F	1 X Navar Married 2 ☐ Married	1 (2)	fas 2 No s. Giva		1 ☐ Yes 2				riiodri, dio.,			
ours ours Fixe	þ	3 ☐ Widowed 4 ☐ Divorced	Yaar	or Datas: WV	/II	10 162 2	LZNVO	эрвспу.			Specif	y:	White
A 12.13-0020 d within 72 hours after giene. Ir than "naturel", or fut the Wed cal Examine	Completed	15. Decedant's (Spacify only highest of		tad)	16a. Dece	dant's Usual	Occu	pation	st of work	cina	16b. Kind of B	usinass/Ind	dustry
Per	ğ	Elementery/Secondery (0-12)		ge (1-4or 5+)	lifa.	DO NOT use	e ratire	ed)			D-1+		0:4
If yield a 1.6. should be filed within a Mantal Hygiene. The marked other than matic event, the Mantal Hygiene.	Š	8				Maint	ena						City
be filed tal Hygid d other event, the	Be	17. Fathar's Nema (First, Middla, La	•							a (First, Middla,		na)	
should I	2	Patrick J. Wa	llace					N	elli	e L. U	'Connor		
Maryland 2 should be file th and Mantai Hy 7 is marked oth traumatic event		19a. Informant's Name/Ralationship			19b. Mail	ing Addrass	(Strae	it and Numb	er or Ru	ral Routa Numbe	er, City or Town	, Stata, Zip	Coda)
1 and 1 health em 27 i		Marie A. Folan	(s	ister)		7 Upri		Ct.	Apt.	D Bal	timore,		21234
Gore, Maryland ZIZID-Uges 1 and 2 should be filled within 72 hat of Health and Mantai Hygiene. If item 27 is marked other than "natur or other traumatic event, ins Medical		20a. Mathod of Disposition 1			20b. Placa of Disp camatary, cra	osition (Nam matory or ot	a of har pla	aca)		Data	20c. Location	- City or To	wn, Stata
Dallimore, bemit. Pages 1 al Department of Hea Moctant: if flem. Iny injury or othe		4 □ Donation 5 □ Other (Spe		rom State	New Cath	edral	Ce	metery	/	11/17/99	Balti	more.	, Maryland
Dallinore, N permit. Pages 1 and Department of Health Important: if Item 27 any injury or other it	Ì	21. Signatura of Funaral Sarvice Lic	ensee Mi	chael F	Canapp 2	2. Nama and	d Addr	ass of Facili	ity		E20E I	lanfa	ad Doad
Depa impo		11.000	),,,	/	ourapp	LEONA	DD	J. RU	ICK	TNC			rd Road ID 21214
-	Н	23a Part 1 Entar the disease or co	mplication	hat causad the	a death. Do not ar							10,1	Approximata
Dhariston		23a. Part1. Entar tha disaasa, or co shock, or haart failura. List on	y one causa	on aach lina.			,						Intarval Batween Onset and Death
Physician /Medical		Immediata Causa (Final											
Examiner		disaasa or condition resulting in deeth)	a	PNEU	Amor								
	-			Du	a to (or as e conse	quance of):							
nsit ed	Examiner		b	HROW			VE	P	ساب	Driverd	DISE	ME	
y xecu al-tra	xa	Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying		Dua	a to (or as a conse	quance of):				,		1	
A CO / COU, artificate be assecuted ing physician and e as the bunal-transit	9	Causa (Disaasa or Injury	c. P		DHECK								
phys the	edicai	that initiated avants rasulting in death) Last		Dua	a to (or as a conse	quance of):							
A ding	Σ Ι		d										
iras that the death certificate be assocuted signed by the attending physician and d be detached for use as the burial-transit	Physician/											-	
the de sched	ysic	Part II. Other significant conditions	contributing	to death but n	ot rasulting in tha	undarlying ca	ausa g	ivan in Part	l.	23b. Dld 1	obacco usa co	_	the cause of death
d by										10	Yes 2□ No	3 Prol	bably 4 Unknow
requires that the een signed by the hould be detache	2											7 04h 184	are autopay findings
been si should l	) tec									perfo	an eutopsy rmad?	av	ere autopsy findings allabla prior to mplation of causa
2 s b	du												daath?
The The ate h	Completed									101	as 2 No	1 0	∃Yas 2□ No
Attending Physician: The is of death.  ector: After this certificate he by the funeral director, page	Be	25. Was casa rafarred to medical axaminar?						26. Plac	a of Daa	th (Check only o	ne)		
Physician: Physician: r this certific eral director,	0	1 Yas 2 No	Hospital:	1 Inpatiant	2 ER/Outpatie	ent 3 DO	AO	ther: 4 N	ursing H	oma 5 🗆 Rasio	dance 6 Ott	har (Specif	y)
Affect Affect funera		27. Mannar of Death 1 ☑ Natural 5 ☐ Pending	28a. [	Data of Injury Month, Day Ye	28b. Tima Injury	of 28	Bc. Inju	ury at ork?		28d. Dascribe !	now injury occu	rred	
Attending or death.  ctor: After by the fune	ati	2 ☐ Accidant invastigat	on			М	1[	∃Yas 2□	No				
ul or Attending after death. Director: After d in by the fune	Ĕ	3 ☐ Suicida 6 ☐ Could not determine	d 286. F	Place of Injury ouilding, atc. (5	- At home, farm, s	treet, factory,	, office	A		28f. Location (S City or Tox		ber or Rura	Il Routa Number,
s after of in ordinate ordinat	Certification:			and the second									
Hospital 24 hours Funeral riely filled		29a. Certifier 1 Certifying 1 (Check only 2 Medical Ex	hysician: To	o the best of m	y knowladga, daa	th occurred a	at the t	ime, date er	nd place,	end dua to tha	causa(s) end m	enner es s	teted.
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	one) 2 Madical Ex		ha basis of axi mannar stated	amination and/or in I.	ivastigation,	in my	opinion, dat	atti OCCUI	ieu ai ma time,	uate and place,	and dua (	riid Cause(s)
within 2 To the comple	Σ	29b. Signature and titla of certifiar				29c.	Licar	nsa number			29d. Data signe	ed (Month,	Dey, Year)
			1 -			1	211	771			HOUSE	DE-E	14 1000
12	}	30. Nama and addrass of person wh	o complated	causa of daatt	h (Itam 23a) (Tvpe								1,122
(1)			MASUE			REEN	5	ST		RAM	DEF I	10	21201
State	6	31. Data filad (Month, Day, Year)		32. Ragistrar's		1			1	1 - 111		- 3	
Registra	_	NOV 1 6 1999	Semen	W A	las	1/3							

MOA I E 1833 Yours of Horres

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of			jiene 🥞 🛒 leg. No.	30009			
	DI	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	th	3. Time of Death			
	Physician /Medical	CATHERINE	DEGNAN	N WAI	LTJEN		NOVEMBE	R 14, 1	999 8:31 PM			
	Examiner	4a Facility Name (If not institution, given Saint Joseph		Center		4b. City, Town, o	Location of Death	4c. County of	Death altimore			
	Funeral Director		Sex 7. Ag	e (In yrs. last birthday) 78 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hr Hours Min		Year) 1921	9. Birthplaca (State or Foreign Country) Maryland			
	p .	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits			
	ahor de la constante de la con	Maryland N/A							112 Yes 2 □ No			
	with the Mar or 28a-f a be notified	10a. Street and Number		Baltimo	10f. Zip Code		T	Og. Citizen of W	hat Country?			
	With With	3 Goodale Place				1212		U.S				
	r Herne 234 rither must Funeral	11. Marilal Status	12. Was Decedent	Ever in U,S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race	- American Indien,			
Baltimore, Maryland 21215-0020	urs a	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  Armed Forces?  If Yes, Give Year or Dates:	No	If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Pue Specify:	rto Rican, etc.)	Specify:	White, etc.			
2-0	ygiene. Ner than "neturn rt, the Wedical	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	pation	odrina	16b. Kind of Bus				
121	ithin Wan Man	Elementary/Secondary (0-12)	College (1-4or 5	ife.	DO NOT use retire	d)	Uning					
12	Hygie Hygie Affect the Co	12 years 17. Fether's Name (First, Middle, Last	1	<u> </u>	Homemaker	19 Mothar's N	ame (First, Middle,	Own H				
and	ntal H ed off even	Joseph P										
7	2 should be filed within end Mental Hygiene. Is marked other than surrette event, the March To Be Comp	19a. Informent's Neme/Relationship		egnan	ing Address (Street	Marga and Number or I	Rural Route Numbe	McMah				
<b>₹</b>	nd 2 strain or train	Norman V. Waltje			Della		timore, N					
re,	ges 1 and 2 should at the first or other traumatic or other traumatic To	20a. Method of Disposition		20b. Place of Disp			Date		City or Town, State			
E	Page ient o mt: if ry or	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			unt Crema		11-16-99	Baltim	ore, Maryland			
alti	permit. Pages 1 and 2 Department of Health Important: If Item 27 Is any Injury or other tra ance.	21. Signature of Funeral Service Lice	nsee	2	2. Name and Addre	ess of Facility			-			
m	90 1 9	Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary										
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused						and 21212 Approximate Interval Between			
	Physician	Shoot, or hour tander. Estigatly							Onset and Death			
	/Medical Examiner	Immediele Cause (Final disease or condition	HNUXIL	ENCEPHA	LUPHIHY				1 HOUR			
		resulting in deeth)	J	Due to (or as a conse	quenca of):				1			
1	axecuted in and rial-transit Examiner		b									
	axecu n and lai-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a conse	quence of):							
8760,	certificate be assecuted nding physician and use as the burial-transit n/Medical Examir	triat initiated events	c	Due lo (or es e conse	anence of							
9	tificat as th	resulting in death) Last		200 10 (01 03 0 0011001	quonico dij.							
SOX	es that the death certific igned by the attending p be detached for use as by Physician/Me		d	1000								
). B	death he atter hed for u	Part II. Other significant conditions of	contributing to death be	ut not resulting in the u	underlying cause gi	ven in Part I.	23b. Did to	obacco use con	tribute to the cause of death?			
P.0	that the sed by the detache	CEREBROVASCULA	R ACCIDENT	יכ			101	es 2⊠ No	3 Probably 4 Unknown			
Ś	w requires that is been signed is should be det	OLIKLIDIKO VADGULA	IK ACCIDENT	. 5								
oro	requires been sign should be						24a. Was a	med?	24b. Were eutopsy findings evailable prior to completion of cause			
3ec	The law require cate has been signed 2 should Completed								of death?			
Vital Record	ysicien: The lav sis certificate has director, page 2 To Be Comp						1 U Y	Λ	1 ☐ Yes 2 ☐ No			
Ĭ	Physician: this certific rai director, TO Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	-1 2 500 to 15	ot all post Ott	hor	eath (Check only of Home 5 Resid		a (Casaiba)			
o	Physic or this control or oral director	27. Menner of Death	28a. Dete of Inju	ry 28b. Time o			-	ow injury occurre				
ion	Attending in death.  Sector: After by the fune	1 Neturel 5 Pending investigatio	(Month, De)	y Year) Injury		rk?  Yes 2∐No						
Division	tal or Attending P at after death. In Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, ferm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,			
	To the Hospital or Attending Phymithin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral Medical Certification; T	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best of miner: On the basis of end manner sta	examination and/or in	th occurred at the ti evestigation, in my o	me, date end pla opinion, death oc	ce, and due to the courred at the time, o	ause(s) end mer late and place, a	nner es steted. nd due to the cause(s)			
	Within Within Comp	29b. Signeture end title of certifier	1 -	~	29c. Licens				(Month, Day, Year)			
	λ	) san		thoo	D302	63		16-15-	-99			
	31/	30. Name end address of person who FRANCIS KHOD,	completed cause of d	eath (Item 23a) (Type,	Print) DRIVE,	TOWSON	, MARYL	AND 21	204			
	State Registrar	31. Date filed (Month, Day, Year)		s Signature	3 Sou	nto			1.00			

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 11:00 PM 11,1999 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) **Examiner** butus If Under 24 Hrs. If Under 1 Yea Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 211-22-788 Usuel Residence of Decedent Director Peges 1 end 2 should be filed within 72 hours after death with the Marylend 10a. Stete 10c. City, Town or Location 10d. fnslde City Limits ir than "natural", or itema 23a or 28a-f ahor the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the Item. Elementery/Secondery (0-12) College (1-4or 5+) tighter 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden 5 Be 2 19e. Informent's Neme/Beletionship (Type, Print) or Rurat Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Num Cutla 20b. Plece of Disposition (Name of 20e. Method of Disposition 1 Dariel 2 Cremetion 20c. Location - City or Town, Stete 3 Removel from Stete permit. Pege Department of Important: If any injury or remator 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name end Address of Facil 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of bying, such as cardiac of shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ate has been signed by the a pege 2 should be detached Pert ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 4 Unknown 1 Yes 2 No 3 Probably Records. Be Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Neturel Injury 5 Pending 1 ☐ Yes 2 ☐ No investigetion within 24 hours after deeth. To the Funeral Director: A 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Manager of the cause (s) and manager of the cause (s) and manager of the time, date and place, and due to the cause (s) and manager as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ecery 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Registrar **DHMH 16 Rev 6/95**

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** NOVEMBER 1999 **JORDAN** WILLIAMS 9 1:45 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Date of Birth (Month, Dey, Year) Aug. 28, 1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 🖾 F 90 Yrs. Maryland Director 217-14-6622 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits **Bhow** must be notified at Maryland 1 ☐ Yes ♀ No Baltimore Baltimore County Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or flams 23s or the Medical Examiner must be r 21234 USA 3014 Second Avenue Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Wes Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be liled within 72 hours after Dopartment of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examines Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Specify: White à ¾ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government N/A Secretary 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 Marie Riehl John Henry Jordan 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ruth D. Megary 2008 Wintergreen Place Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, cremetory or other ptece) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Parkwood Cemetery 11-12-1999 Baltimore. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, hock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) SMALL BOWEL OBSTRUCTION Examiner Due to (or as a consequence of): Examiner physician and the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): for use as 980 signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Division of Vital Records. þ The law requires Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to ACUTE ON CHRONIC RENAL FAILURE completion of cause of deeth? page 2 s 1 Yes 2 No 1 ☐ Yes 2 No certificate Mospital or Attending Physician:
 24 hours after death.
 Funerel Director: After this certifical etely filled in by the funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier To the Hoep within 24 hou To the Fune completely fi Medical 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier D37254 9 6

20

State Registrar NOV 1 6 1999

BOON P. LIM M.D.,

7601 OSLER DRIVE, TOWSON, MARYLAND 21204
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

prove to spendy MOA 1 8 4838

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

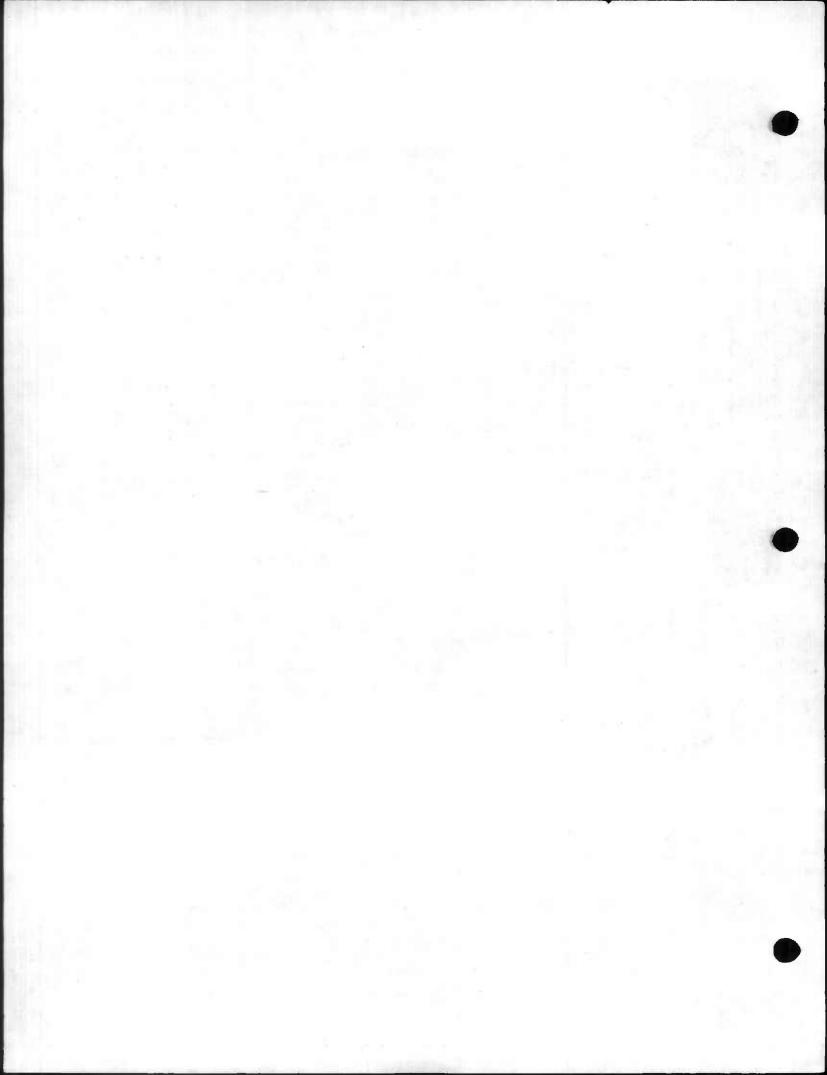
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			1. Decedent's Name (First,	Middle, Li	ast)							2. Date of D Month		Day	Year	3. Time of De	eath
	Physicia	_	Norman W	iteh	ead							OCTOB		28,	1999	0732 I	M/
	/Medica Examine		4e Facility Neme (If not ins	titution, gi	ve street and nu	ımber)				1	4b. City, Town, or L			4c. County			
A	LAGITITIO	-1	1455 LIGHT	STREE	ET						BALTIMOR	Œ					
<u> </u>	-		5. Social Security Number	6.	Sex	7. Age (	in yrs. last b	irthday)	If Under 1	Year	If Under 24 Hrs.	8. Date of B	irth		9 Rinthn	lace (State or I	Foreign
١.	Funeral Director	ı			1 🔀 M 2 🗆 F		65	Yrs.	Months I	Days	Hours Min.	8. Date of B				lace (State or F try)	or orgin
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	P. M.	Ì	10a. State 10b. C			1	Oc. City, To	wn or Lo	cation						1	0d. Inside City	Limits
	Many	5	Unk. unl	nown			unkno	T.773								1 Yes 2	□ No
	28a	Director	10a, Street and Number	LIOWII			unkne	WII	10f. Zip C	ode			100	Citizen of I	What Cour	to 2	
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	should be filed within 72 hours after death with the Maryland nd Mentel Hygiene.  marked other than "natural", or itema 23a or 28a-f show umstic event, the Medical Examinar must be notified at	Funerai			10 M - D -	- 4 - A E	- 110	40.3						·S·A		in to the	
	ab re de	Š	11. Marital Status	AVS. 2411	12. Was Dec Armed Fo	orces?	er in U,S.	13. \	Was Deceder f Yes, specify	t of F	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	0-		ce - Americ ck, White,		
20	and a		1 Never Merried 2		1 (X) Yes If Yes, Gi	ive			1 🗆 Yes 25	No	Specify:			Specif	w. Whi		
8	iral.	d by	3 ☐ Widowed 4 ☐ Div	orced	Year or D	Dates:							,				
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7	ygie t	3	unnknown	,	unknow	n	u	nkno	own								
Pu	S of the second	Be	17. Father's Name (First, N	iddle, Lasi	")						18. Mother's Nam	e (First, Middle	e, Maid	len Suman	ne)		
<u>/a</u>	Vent Vent	၉	unknown								unknown						
an	of but		19a. Informant's Name/Re	ationship	(Type, Print)		19	b. Meilir	ng Address (S	Street	and Number or Rur	al Route Numi	ber, Cit	y or Town	State, Zip	Code)	
Σ	27 is		Michele Whit	ehea	d/daugh	ter	2	2023	Griff	is	Ave., Bal	ltimore	, M	D 212	230		
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Manylen Department of Haalth end Mentei Hygiene. Important: if item 27 is marked other than "natural", or frema 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar mast be notified at page.	ľ	20a. Method of Disposition				20b. Place	of Dispo	sition (Name	of		Date	20c.	Location	- City or To	wn, State	
20	90e		1 Burial 2 Crem			State	cemen	ery, cren	netory or other	er pied	Ce)						
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1	Physician		(													Onset end De	
1.	/Medical	-	Immediate Cause (Finel		Arter	rinec	lemt	ic C	amima	raci	cular Die	0200			1		
	Examiner		disease or condition resulting in death)  Arteriosclerotic Cardiovascular Disease  Due to (or as a consequence of):														
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89		ğ	resulting in death) Last			Du	e to (or as a	conseq	uence or):								
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o.	0 0 7	3	Part II. Other significant co	nditions (	contributing to d	eath but r	ot resulting	in the ur	nderlying cau	se giv	en in Part I.	23b. Dio	tobac	co use co	intribute to	the cause of	death?
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Division of Vital	Physician: r this certific rel director,	2	1)XIX(es 2 □ No 27. Menner of Death		28e. Dete		2 ER/C	Time of			4 Unursing Ho	28d. Describe				V)	
5	After fune	5	1 XX eturel 5 □ F	ending	(Mon	th, Day Y	ear)	tnjury	M	. Injur	k? Yes 2□No	20d. Describe	7110W II	ijury occur	100		
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	To the Mospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	ဒီ 🛚															
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	To To	Σ	29b. Signature end title of o	ertifier	11				29c. l		e number					Day, Year)	
			Mounta	9 (1)	LoMh	M				O.	.C.M.E.		OC	TORE	K 28,	1999	
		-	30. Name end eddress of p	erson who	completed cause	se of deat	h (Item 23a)	(Type	Print)								
			Margarita							, 1	Baltimore	. Marvi	land	212	01		
	State		31. Date filed (Month, Day,				Signature	1	-								
	Registra	-		161	999	150	مصد	D.	000	21	2						

NOVIETES James B. Spaller

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 6 0 9 Certificate of Death

			C	ertificate of L	Death	Reg	. No.	000	02			
	Diam'r.	Decedent's Name (First, Middle, Last)			2	. Dete of Deeth Month	Day	yaar 3. Ti	ima of Death			
	Physician /Medical	Edith Alberta Winter	•		N	lovember			:20 A.M.			
	Examiner	4a Facility Name (If not institution, give street and number	or)	4	b. City, Town, or Loca		4c. County	of Deeth				
		2451 Harriet Avenue			Baltimore	2	N/	A				
	Funeral Director	300-48-2933 1□M 2ÅF	Age (In yrs. last birthd 68 <sup>Yrs</sup>	Months Dave	Hours Min.	Date of Birth (Month, Day, Y Dril 19	, 1931	9. Birthplace (S Country) W. Vir	ginia			
	yland M M	Usual Residence of Decedent  10a. State 10b. County	r Location		- 1	A	10d. Ins	oide City Limits				
	ter death with the Maryland there 23s or 28s-f show the must be notified at Unnered Director	Md. N/A	Baltim	nore				10	XYes 2□No			
	or 28e-f s be notified	10e. Street and Number		10f. Zip Code		10g	. Citizen of W					
	with w			212			U.S.					
020	ors after alf. or he Examine by Fur	3 Widowed 4 □ Divorced If Yes, Give Year or Deter	χNo	13. Wes Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 20 No	spanic Origin? (Speci n, Mexican, Puarto Ri Specity:	ty Yes or No- can, etc.)		- Amarican Indi c, White, etc. White				
50	72 ho	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occupa	ation		b. Kind of Bu	siness/Industry				
21215-0020	ed within 72 ho yglene. Ne then "neturn f, the Medical.	Elementary/Secondary (0-12) College (1-4c	life	e. DO NOT use retired, Homemak			Hor	ne				
P	dai Hyg	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, Ma	iden Surname	9)	E EEDIL			
yla	Menta Menta arked arked	William Daniel Holt			Mary	Ellen	Johns	on				
Maryland	2 sty a manual reum	19a. Informant's Name/Relationship (Type, Print)		lailing Address (Street a								
-	1 and Health em 27 ther t	Linda Hatfield ( Daughter 20a. Method of Disposition	,	J. DUX 244 isposition (Name of crematory or other place				City or Town, St	ete			
altimore,	ages ant of y or o	1 M Burial 2 Cremation 3 Removal from Sta										
Baltil	emit. F Separtm mportar my Injur	Glen Haven Memorial Park 11/15/99 Glen Burnie,  21. Signature of Fyneral Service Licensee  Kevin E. Ecker McCully-Polyniak Funeral Home, P.A.  237 E. Patapsco Avenue Baltimore, Maryla										
_	40240	23a. Pert1. Enter the disease, or complications that caus		237 E. Pat	apsco Aven	ue Balt	imore,	Maryland	d 21225			
).	Medical Examiner  behavioral Examiner  belavioral Examiner  color Examiner	b	Due to (or as a con		CellLu	ng Carc	nom		onths			
60,	clan a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits						1				
ox 68760,	requires that the death certificate be associed seen signed by the attending physician and should be deteched for use as the burial-transit sted by Physician/Medical Examil	resulting in death) Last	Due to (or es a con	sequence of):								
Box.	attending for use	Part II. Other significant conditions contributing to death	but not reculting in th	no underhang cause give	on in Part I	23h Did tohi	ACCO HER COR	tribute to the c	ause of death?			
P.0.	res that the death certification by the attending to detected for use a by Physician/M	E.m. ahusema	Dut not resulting in an	ie underlying cause give	त्रा वा र शर्ष.	1 Yes		3 Probably	4 🗆 Unknown			
Records,		CoronaryArter	Disea	26		24a. Wes an o		24b. Were eut available completio of deeth?	prior to on of cause			
R	yelclen: The lew s cartificate has director, page 2 To Be Compi	1	,			1 ☐ Yas	2 No	1 🗆 Yes	2× No			
Vital	cartificate ractor, pag	25. Was case referred to medical examiner?			26. Place of Deeth (	Check only one)						
of V		1 ☐ Yes 2 No Hospital: 1 ☐ Inpe	atient 2 ER/Outpe	atient 3 DOA Othe	97: 4 Nursing Home	e 5 Residen	ce 6 □Othe	or (Specify)				
n o	wher the uners	I Mitaturat Oli Growny	njury 28b. Tim Day Year) Inju	ry Worl		d. Describe how	injury occurr	ed				
Division	tal or Attanding P as after death. at Director: After led in by the funer Certification:		Injury - At home, farm, etc. (Specify)		Yes 2 □ No 28	Location (Street and Number or Rural Route Number, City or Town, State)						
۵	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  29a. Certifier (Check only one)  2 Medical Examiner: On the basis and manner and manner	of examinetion end/o						euse(s)			
	outher outhough	29b. Signature and title of certifier		29c. License	number	290	. Date signed	(Month, Day, Y	'ear)			
	- s - ō	Qulie Brahme	,MO	DOO	51770	NE	vem	ber 13 MD 21	1999			
		30. Name and address of person who completed cause of	f death (Item 23a) (Ty	pe, Print)	111	R 11.		UT -	1700			
	State	31. Date filed (Month, Day, Year) 32. Regi	ン Johns I strats Signature	TOPKINS H	ospitul (	bitin	nove,	riv di	28/			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item#26 perPhyG777 11/16/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Day **Physician** November 13, 1999 Jane 10:45 P.M. Mary Wade /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Care Center Linthicum Anne Arundel If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 M 2 X F Months 76<sup>Yrs.</sup> Director 214-22-0803 6, Aug. Maryland Usual Rasidence of Decedent with the Marylend 10a Stete 10b. County 10c. City, Town or Location 10d Inside City Limits show Pages 1 and 2 should be filed within 72 hours efter death with the Maryler nant of Health and Mentel Hygiene. ant of Health and Mentel Hygiene. ant: If Item 27 Is marked other than "natural; or frams 23s or 28s-f show any or other traumstic avent, the Medical Examina mant be notified. 1X Yes 2 No Director N/A Baltimore 10e. Streat end Number 10f. Zip Code 10g. Citizen of What Country? 1600 Popland Street U.S.A. 21226 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☑ Widowed 4 □ Divorced Yaer or Detas: White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) 12th Collaga (1-4or 5+) Vault Manager Md. National Bank 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Mary E. Walters Wilber John Foxwell 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 sh Department of Heelth end Important: If Item 27 Ia m any Injury or other traum once. David J. Wade ( Son 163 Windsor Court Hanover, Pennsylvania 17331 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 Cremation 3 Removel from State Cedar Hill Cemetery 11/17/99 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ecker McCully-Polyniak Funeral Home, P.A. Kevin E. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23e. Part 1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haen failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finat YEARS diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner physicien end s the bunal-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avents resulting in death) Lest Dua to (or es e consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 28 No 3 | Probably 4 | Unknown Be Completed by Division of Vital Records, The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? or Attending Physician: 25. Wes casa raferred to medicat 26. Place of Death (Check only one, axaminer? Other: 4 Nursing Home Strestoence 6 DOther (Specify). hesapeake Hospital: No edical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Mennes of Deeth 28b. Time of 28c. Injury et Work? Neturel 5 Pending 1 Yes 2 No death. 2 Assident Invastigation 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledga, daath occurred et the tima, data and place, end dua to the cause(s) end menner as stated.

| Indical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and little of pertifier 29c. License number 29d. Date signed (Month, Day, Year) ME D29373 99

WICHTE

**DHMH 16 Ray 6/95** 

State

Registrar

30. Name and address of person who complete

NOV 1 6

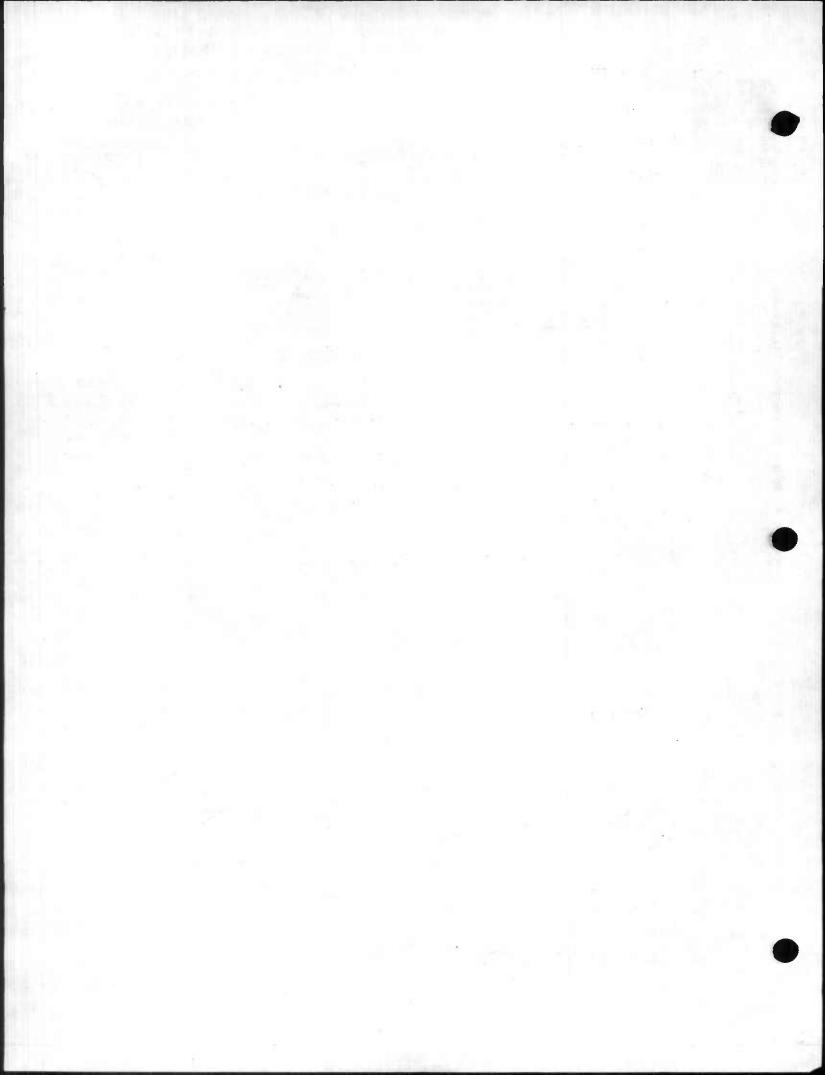
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BRIC J. SETFTER 10755 FALLS RO, SUITE 200 LUTHERVILLE, MO 21093

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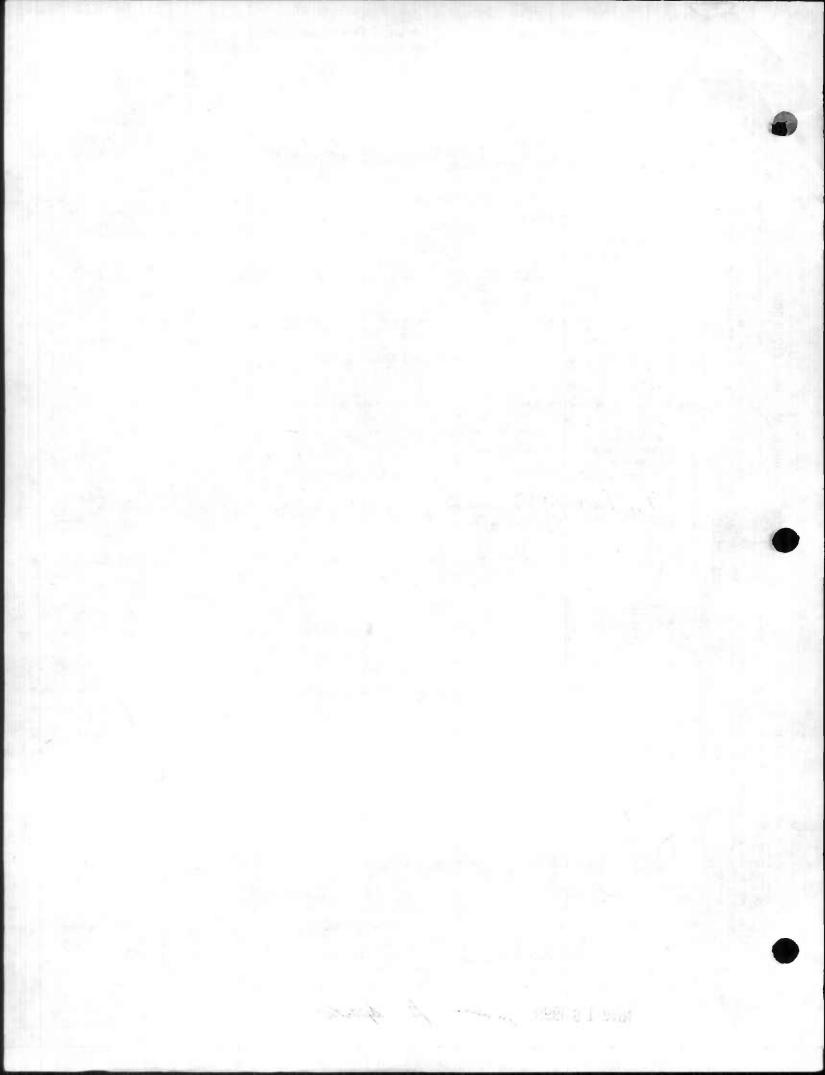
cause of death (ttem 23a) (Type, Print)

32. Registatr's Signeture



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Department of Health a Certificate of Death	and Mental Hy	rgiene 9	9 36011			
	10.00	Decedent's Name (First, Middle, Last)	2. Dete of D Month	eath	3. Time of Death			
	Physiciar /Medica	CHADIES D WIECAND	NOV.	14 199	9 2:45 am			
	Examine	4a Facility Name (If not institution, give street and number) 4b. City, Tov	wn, or Location of Dea					
			tpoint		ltimore			
ı	Funeral Director	5. Social Security Number 218-05-4158 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 2 Hours 81 Yrs. Months Deys Hours	24 Hrs. 8. Date of Bi Min. (Month, D Aug 24	rth ey, <i>Year)</i> ! 1918	9. Birthplaca (State or Foreign Country) MAryland			
	pu &	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	Mary 1 ah	MD Baltimore Eastpoint			1 □ Yes → No			
	or 28a-f a	10e. Street and Number 10f. Zip Code		10g. Citizen of \	What Country?			
	With the state of			USA				
5-0020	72 hours efter deeth with the Maryland natural; or items 23a or 28a-f show diest Examiner must be notified at the country of t	3 Widowed 4 Divorced   If Yes, Give   1 Yes 2 Divorced   Year or Dates:	gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Rac Blee Specify	ea - American Indien, ck, White, etc. y: White			
5-0	natural',	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	t of working	16b. Kind of B	usiness/Industry			
2121	c	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)		Genera	1 Ship Repai			
7	filed within Hygiene. ther then "		r's Neme (First, Middle					
an	d be find be done	331 772	Anna Pr		10)			
Maryland	d 2 should be filed within the end Mental Hyglene. 7 is marked other than treumetic event, the M	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number			Stete, Zip Code)			
	C = 0 -	Violet Wiegand / wife 440 Oriole Road		re Md. 2				
re,	- 9 5 5	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -	City or Town, Stete			
E	Pages mrt. If its iry or o		11/17/99	Baltin	more Md.			
Baitimore,	permit. Page Depertment of Important: if eny injury or auca.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Connelly Fun	neral Home					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only the cause on each line.	e. Baltimor cardiac or respiratory	e Md. 21 errest,	Approximate Interval Between			
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Metastalic Luig C  Due to (or es a consequence of):	A		Onset end Deeth			
8760,	ste be axecuted thy sician end the burlel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that intillated events	Due to (or as a consequence of):  Due to (or as a consequence of):					
Box 68	ist the death certificate d by the attending physicisched for use as the physician Medic							
	0 0 2 7	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	. 23b. Dic	l tobacco use co	ntribute to the cause of death?			
8, P.O	requires that the de- sen signed by the s hould be deteched in		1	Yes 2□ No	3 Probably 4 Unknown			
Records,	a been a 2 should			s an autopsy ormed?	24b. Were eutopsy lindings available prior to completion of cause of deeth?			
	The late he page		10	Yes 200 No	1 ☐ Yes 2 ☐ No			
Vital	certificant rector,	25. Was case referred to medical 26. Place	ol Death (Check only	one)				
of	the state of	1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu		idence 6 Oth				
	tal or Attending P re after deeth. el Director: After ed in by the funan Certification:	27. Manner of Death   Catural   5   Pending   28a. Date of Injury   28b. Time of Injury   28c. Injury et Work?   28c. Accident   28c. Injury et Work?   1   Yes 2   1	-	how injury occur	red			
Division	at or Att	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)	28I. Location City or To	(Street and Numi own, State)	ber or Rurel Route Number,			
	To the Heapital or A within 24 hours after To the Funeral Dire completely filled in B Madical Carti		d plece, and due to the th occurred et the time	ceuse(s) and me , date end place,	enner as stated. end due to the cause(s)			
	withir To th comp			29d. Date signe	d (Month, Dey, Year)			
		D26833	-	11-	1599			
	40	30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)						
	State Registrar	31. Date filed (Month, Day, Year) NOV 1 6 1999  32. Registrar's Signature & Apocks						



## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	ai yiai iu i	•	tificate o		id Merital Fly	Reg. No.		16012
	DI		1. Decedent's Nama (First, Middla, Last,	j			-		2. Date of De Month	ath Day	Year	3. Tima of Death
	Physici /Media		Thomas Wilson W	halen					Novemb		999	5:45 AM
	Examir		4a Facility Nema (If not institution, giva	street and number)				4b. City, Town	, or Location of Deat	h 4c. County	of Deeth	
			2108 Pelham Aven	ue				Bala	timore		N/A	
	Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. last	birthday)	If Under 1 Ye		Hrs. 8. Data of Bir Min. (Month, Da	th Yourl	9. Birthp	placa (Stata or Foreign
	Director		217-07-9501 Usual Residence of Decedent	M 2□ F 8	6	Yrs.	Months Day	rs Hours (	Jan. 6	, 1913	N	laryland
	anyland ahow	_	10a. State 10b. County		10c. City, T						1	0d. Insida City Limits
	M Page	cto	Maryland N/A			i	Baltimo.					
	igh th	E .	t 0e. Street and Number				10f. Zip Code			10g. Citizen of 1		itry?
	23a	rai	4322 Brehms Lane					1206		u. s		
	r de	Pur	11. Maritel Status	12. Was Decedent i Armed Forces?		13. V	Vas Decedent of Yes, specify C	f Hispanic Origin uban, Mexican, P	? (Specify Yes or No Puarto Rican, atc.)	- 14. Rad Bla	e - Americ ck, Whita,	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if Itam 27 is marked other than *natural', or itema 23a or 28e-f ahow any folury or other traumatic avant, the Medical Exercises must be notified at page.	by Funeral Director	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yas, Give Year or Detes:	10		□Yes 201		o Specify:			iite
9	2 ho	pe	15. Decedent's Edu	cation	1	6a. Deced	ent's Usual Occ	cupation		t6b. Kind of B	usinass/Inc	dustry
2	hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(4)	lifa. E	kind of work doi OO NOT use ret	ne during most of ired)	working	Balti	more	City
7	d will	E	10th Grade	College (1-4015	~	Pol	ice Off	icer				irtment
ष्ट	othe Hy	Bec	17. Father's Nama (First, Middle, Last)					18. Mothar's	Nama (First, Middle	Maidan Suman	1a)	
a	Ald by Al	TOE	Lawrence Whalen					Eliz	zabeth Jef	brey		
and	short and		t 9a. tnformant's Name/Relationship (Ty	pe, Print)	1	9b. Meilin	g Address (Stre	et and Number o	or Rural Routa Numb	er, City or Town,	Steta, Zip	Code)
Σ	alth a 27 is		Thomas Brian Whale	n (Son)	8	3815	Spring	Road. Bo	altimore,	Md. 212	34	
e.	A Head		20a. Mathod of Disposition		20b. Place	e of Dispos	sition (Nama of natory or other p		Dete	20c. Location		own, Stete
E	Page ent of rt: #		1 (X Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from Stata			Cemete		11/15/99	Baltim	one.	Maryland
Baltimore,	ortan		21. Signature of Funeret Service License	90	7.000	22	. Name and Add	frass of Facility			, ,	
ä	Depa impo		Durin Co U	ulle	u				al Home In 2. Baltimo		ylanc	1 21213
			23a. Part1. Entar tha disease, or compli shock, or heart failure. List only or	cations that caused na cause on pach lin	the death. [							Approximata Intarval Batween
	Physician /Modical		Immediate Cours (First				6	. /			l l	Onset end Death
	/Medical Examiner		Immediata Causa (Final disease or condition rasulting in death)	ne	Mos	rai	3 Cr	upty	seme	•	i	Je an
		_	rasulting at obatily	11	Dua to (or as	a conseg	uence of):		,		1//	
}	D #	dical Examiner		thy	hour	en	sion				- 4	
	and I-tran	xan	Sequentially list conditions, if any, laading to immediata cause. Enter Underlying	(	Due to (or as	a conseq	uence of):					
68760,	be e) buria	E	Cause (Disease or Injury								Ì	
87	icate be executed physician and s the burial-transit	d	thet initiated events rasulting in death) Last	1	Dua to (or as	a consequ	uence of):					
	ding ding			l							ļ	
Box	atten for u	Physician/M										
P.O.	the de	ysi	Part tl. Other significant conditions con	tributing to death bu	ıt not rasultin	g in the ur	nderlying causa	given in Part t.	23b. Did	tobacco use co	0.0	o the cause of death?
	law requires that the death certif as been signed by the attending of 2 should be detached for use a	by Ph							1	Yss 2□ No	3 Pro	bably 4⊡Unknown
Records,	quire and b	8								an eutopsy ormed?	24b. W	are eutopsy findings
00	w re	je							— pen	nneu r	co	empletion of cause daath?
Re	he la B has	Completed								Yas 200 No		☐ Yes 2☐ No
Division of Vital	ificat or, pa		25. Was casa refarred to medical					26 Pleas of			1	3165 2010
5	cert	o Be	examiner?	lospital:	at all EB	/Outpatien	t 3D DOA	Whor:	Death (Check only only only only only only only only		nar (Specif	Real Prine
o	Phy r this	1: 70	27. Manper of Death	28a. Data of Injur	y 28	b. Tima of	28c. Ir			how injury occur		berg. aring
0	Afte fund	to	t Natural 5 Pending 2 Accident invastigation	(Month, Da)	Year)	tnjury		Vork? ∐Yas 2∐No				/
S	dea ctor	fica	3 Suicide 6 Could not be	28e. Piece of Inju	ury - At home	, farm, stre	et, factory, offic	29	28f. Location (	Street end Numi	per or Run	al Routa Number,
	after Direct	Certification:	4 Homicide	building, atc	. (Specify)				City or To	wn, Stete)		
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying Phys	icien: To the best o	of my knowled	dge, death	occurred et the	time, date end p	place, end due to the	ceuse(s) end m	enner es s	teted.
	P Fu	edical	(Check only 2   Medical Examinate)	ner: On the besis of manner ste	examinetion ted.	and/or inv	restigation, in m	y opinion, daath	occurred at tha tima,	data and place,	and dua to	tha cause(s)
	withii To th	ž	29b. Signature and title of certifier		^		29c. Lice	ense number		29d. Deta signe	d (Month,	Day, Year)
			1 // lest 16	YG M	لا		00	104126		11/15	751	<u></u>
	10		30. Nama and eddrass of person who co	mpleted cause of de	eath (Item 23	a) (Type. I						
	10		Alborro I ?	117 M)	7110		SLER DR	#103-	Towpon	ر ليه	1201	1
	Sta	te	31. Data filed (Month, Day, Year)	32. Registra	ar's Signature		1	1		ge '		
	Registr		NOV 1 6 1999	Serve	1	. 10	parks	•				

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F	rank Bre					of Maryla		•			and M	-		9	9	361	012
			1. Decedent's Nama (First, Middla, Last)  2. Data of Death											3. Tim	e of Death		
tar death with the Meryland	Physicia		Frank Brennon								Month Octobe	er 5,	199	Year 99	1:1	11 p.m.	
	/Medica Examine									wn, or Lo	r Location of Death 4c. County of Death				LI Pilli		
	Zaminio		2241 Annapolis Road Baltime							imor	re N/A						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last					birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			24 Hrs. Min.	8. Data of Bir (Month, Da	th v. Year)	(ear) 9. Birthplaca (Stata or F			ta or Foreign
	Director		official and a second				70 Yrs.					unknown			unknown		
	bue *	- 1-	Usuel Rasidence of Decedant  10a. Steta 10b. County	ity, Town or	n or Location					1	Od. Insid	e City Limits					
	f sho	6															Yas 2□ No
	28. Trout	<u> </u>	unknown unknown unknown  10e. Street and Number 10f. Zip Cc										10g. Citiz	en of W	/hat Coun	itry?	
	ith with the Merylen 23a or 28a-f ahow	<u>ב</u>	2241 Annapolis Road						21230				USA				
	tar deat	Funeral Director	11. Marital Status unknown 12. Was Dacedent Ever in Armed Forcas?			cedent Ever in I	J,S. 1	3. Was De	edent of H	lispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, Whita, etc.				n,
	or its		1 Never Married 2 Marr	ied	1   Yas 2   No					Specify:			Specify:			ia, eic.	
Š	Prediction of the second	D D	3 Widowed 4 Divorced		Yaar or Datas: UNKNOW			m			unknown			White  16b. Kind of Business/Industry			
e, Maryland Z1Z13-	72 hours "natural",	Completed	15. Deceden (Specify only higha:	t's Educa st grada (	ition complated)	)	(Gi	cedent's U	work dona	during most	t of work	ing	16b. Kir	nd of Bu	siness/Inc	lustry	
	d withi	Ĕ	Elementery/Secondery (0-12) Collega (1-4or 5+) unknown			'life. DO NOT use retired) unknown				,	ınkn	Own					
	<b>EIDE</b> ,	) 8	17. Father's Nama (First, Middle, Last)							18. Mothe	18. Mother's Nama (First, Middle,						
	0 5 0 0	0	unkn	own						unknown							
	S D E E	_	19a. Informant's Name/Ralations	hip <i>(Type</i>	e, Print)		19b. Ma	19b. Mailing Addrass (Street and Number or Ru				aral Route Number, City or Town, Stata, Zip Code)					
	C m N F		.unknown 0	.C.M.	E.			unknown 111 PEN			ENN S	STREET, BALTIMORE, MARYLAND 2				AND 2	1201
	_ 7 5 5		20e. Mathod of Disposition 1 □ Burial 2 □ Cramation	3	moval from		Plece of Dis cematary, c	sposition (fi ramatory o	lama of r othar plac	ce)	1	Data	20c. Loc	cation -	City or To	wn, Stat	B.
	mit. Pag sartmant cortant: I injury c		4 ☐ Donation 5 MOther (S	pecify)	in st	ate					i						
	permit. Pagas Department of Inportant: If Ite any injury or of		21. Signatura of Funeral Service Kona	Licensee	Wad	le, Dire	ctor	22. Name	and Addre	rat Englis	y Boa	ard 655	W. E	alt	imore	e St	
	00549		Baltimore, MD 21201  23a. Part1. Entar tha disaesa, or complications that caused tha death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on each line.  Approximate Interval Between														
	Physician /Medical Examiner	ner	Immediata Causa (Final disaasa or condition resulting in deeth)  a. Atheros/trotic Candiovas(ular disease)  Due to (or as a consequence of):										ino Deali				
'n	be executed sloten and burist-transit	Examiner	Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Cause (Disease or injury	<b>6</b> b	Due to (or as e consequanca of):												
.U. BOX 68/6U,	s be	=	Cause (Disease or injury that initieted evants rasulting in daath) Lest		Dua to (or as a consequance of):												
	sicien: The law requires that the deeth cartifice certificate hes been signed by the attending phy frector, page 2 should be detached for use as the contract of the contract	rnysiciaryme	d											1			
0	daeti	300	Part II. Other significant condition	ns contri	ibuting to d	death but not re	sulting in the	underlying	g causa giv	given in Pert I. 23b. I			Did tobacco use contribute to the cause of death?				
5	at tha	Ē	Taken against a statistical solutions and the statistical solutions and the statistical solutions and the statistical solutions and the statistical solutions are statistical solutions.								10	1 Yes 2 No 3 Probably 4 Unkn			4 🗆 Unknown		
ecords, P	igned bed																
	requi	5										24a. Was	an eutop med?	sy	-av	ailable pi	osy findings rior to of ceuse
	hes to	d										Limi	•		of	death?	
To the Hospital or Attending Physician: The la	r, pag	o Be Completed by											Yes 2	]No	1,2	Yas	2□ No
	certification in a contraction in a cont		25. Was casa refarred to medical axaminar? 1 X Yas 2 No	_	spital:	Inpatiant 2	1500	a 🗆	Oth	300		h (Check only i		70*	(0		
	r this	-  -	27. Mannar of Death		28a. Date	of Injury	28b. Time	a of	28c. Injui		rsing ric	ma \$CXResi 28d. Describe				7)	
	offing th.: Afta a fun		1 Netural 5 ☐ Panding 2 ☐ Accidant Invastig		(Month, Day Year)					ork? ]Yes 2 ☐ No							
	r Atte	Cerumoanon	3 Suicide 6 Could not be detarmined 28a. Placa of Injury - At homa, building, atc. (Specify)					a, farm, street, factory, office			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)						
	in i																
	Hosp 24 hou Fune tely fi	BOILDE	29a. Cartifiar 1 Certifyin (Check only one) Medical	g Physic Examine	r: On tha b	e best of my kn pasis of axamin	owledga, da ation and/or	ath occurre investigati	ed at tha tir on, in my c	ma, data an opinion, dee	d place, th occur	end due to the red at the time,	cause(s) date and	end me place, a	nnar as si and due to	teted. tha cau	se(s)
a t	ithin o the omple	-	one) A and mennar stated.  29b. Signetura and titla of certifiar 29c. License number									29d. Date signed (Month, Day, Year)					
	⊢ ≶ ⊨ ō		Mt. M. A Manti-					MP O.C.M.E.					October 6, 1999				
	M	-	30. Nema end addrass of person	who com	pleted cau	sa of death (Ite											
	M		Stephen S.	Ra					Stree	t, Bal	ltim	ore, Ma	ryla	nd 2	21201		
	State		31. Date filed (Month, Day, Year)		32. F	Registrar's Sign	atura										
	Registra		NOV 1 6 199	ч	Pag.	The same	M	Ann.	1								

NOV I 6 1999 James & Spares

#### Certificate of Death 1. Decedent's Nama (First, Middle, Last) **Physician** Pearl Brown · /Medical 4b. City, Town, or Location of Death Facility Nama (If not institution, giva street and number) **Examiner** Mary land Medicine University 01-7 Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 62 Yrs. | Months Days Hours Min. | 02-20-37 5. Social Sacurity Number 6 Sax **Funeral** 10 M 20F 213-34-8894 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c City Town or Location 10a State 10h County show item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Experiment must be notified at MD Baltimore NA Director 10e. Street and Number 10f. Zip Code 1105 Myrtle Avenue 21201 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 Pes 2 No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Naver Married 2 Married 1 Yas 2 No Specify: P. NaME: Pearl þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) permit. Pages 1 and 2 should be filed within Department of Heelth and Mantal Hygiana. Important: If few 77 is marked other than any Injury or other treumeric average. Flementery/Secondery (0-12) 7th Grade College (1-4or 5+) Never-worked 17. Father's Name (First, Middle, Last) Johnny Williams 19a. Informant's Name/Relationship (Type, Print) Wilbert Brown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MARINE

WM.C.March FH 1101 E. N

23a. Part1. Enter the disease, or compositions that caused the death. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only to be cause on each line. WM.C.March FH 1101 E. North Avenue Approximate interval Between Onset and Death bneumani or 12 412S Due to (or es a consequence of): accident erabro rascular 104-5 1548 mellitus 1/

**Physician** /Medical Examiner Examiner

physician end s the buriel-transil 88 esn for signed by the e paga 2 s

Physician/Medicai

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Completed

Certification: To

edicai

fillad in by

completaly

24 hours a

To the To the To the

death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

certificate funeral director, this After after death. Director: Aft

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Immediate Cause (Final disaasa or condition resulting in death)

Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last

tenive Deceptus ulcars 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to complation of cause of death?

25. Wes case referred to medicel examiner? 1 Yes 21 No

4 Homicide

29a. Certifier

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Watural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-30494

Dearn hedla I contin , sil south charles street K. DESAIM

31. Date filed (Month, Day, Yaar) 32. Ragistrar's Signajura

NOV 1 7 1999

Registrar **DHMH 16 Rev 6/95** 

0615

3. Tima of Death

 Birthplace (State or Foreign Country) MD 10d. inside City Limits

★SYes 2 No

10g. Citizen of What Country?

USA 14. Race - Amarican Indian.

Black, Whita, etc.

Specify: Black

16b. Kind of Business/Industry

Unemployed

18. Mother's Name (First, Middle, Maiden Sumame)

Josephine Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201

Reg. No.

Day

12

4c. County of Death

2. Date of Death Month

Baltimore

November

1105 Myrtle Avenue Baltimore, Maryland 20c. Location - City or Town, Stata Date

Arbutus Mem. Pk. Cem. 11-17-99 Arbutus, MD.

22. Name and Address of Facility Baltimore, Maryland 21202

Due to (or as a consequence of): fly ponton sian Dua to (or as a consequence of):

10 hours

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

24a. Was an autopsy performed?

1 Yes 2 DNo 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

11 - 13 - 99

allmane



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician 5 Barts 1911 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Un 13 alt If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) **Funeral** Days 1□ M 2 2 4 18-56-0833 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City /Fown or Location 28a-f ahow 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ "natural", or Nems 23s Funeral 12. Was Decedent American Indian. 11. Marital Status Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Yes 2 Who If Yes, Give / Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or haven injury or other trauments. 1 Never Married 2 Merried 1 □ Yes 205-Mo þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiginal) 15. Decedent's Education city only highest grade comp ny/Secondary (0-12) on (1-4or 5+) 88 od of Dispositio 20b. Pu Burial 2 Cremation 4 Donation 5 Dother (Specify) 21 Signature of Funeral Service Licens sase, or complications that caused the death. Do not enter the mode of dying, are. List only get cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner 4 hate the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 Yes 1 Yes 22 No 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 3□ DOA 27. Manner of Date 28d. Describe how injury occurred tnjury et Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No

Division of Vital Records, P.O. Box 68760, attanding physicien To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Baltimore, Maryland 21215-0020

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) mination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 172126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Maiden Choice

Come

Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

31. Date filed (Month, Day, Year) NOV 1

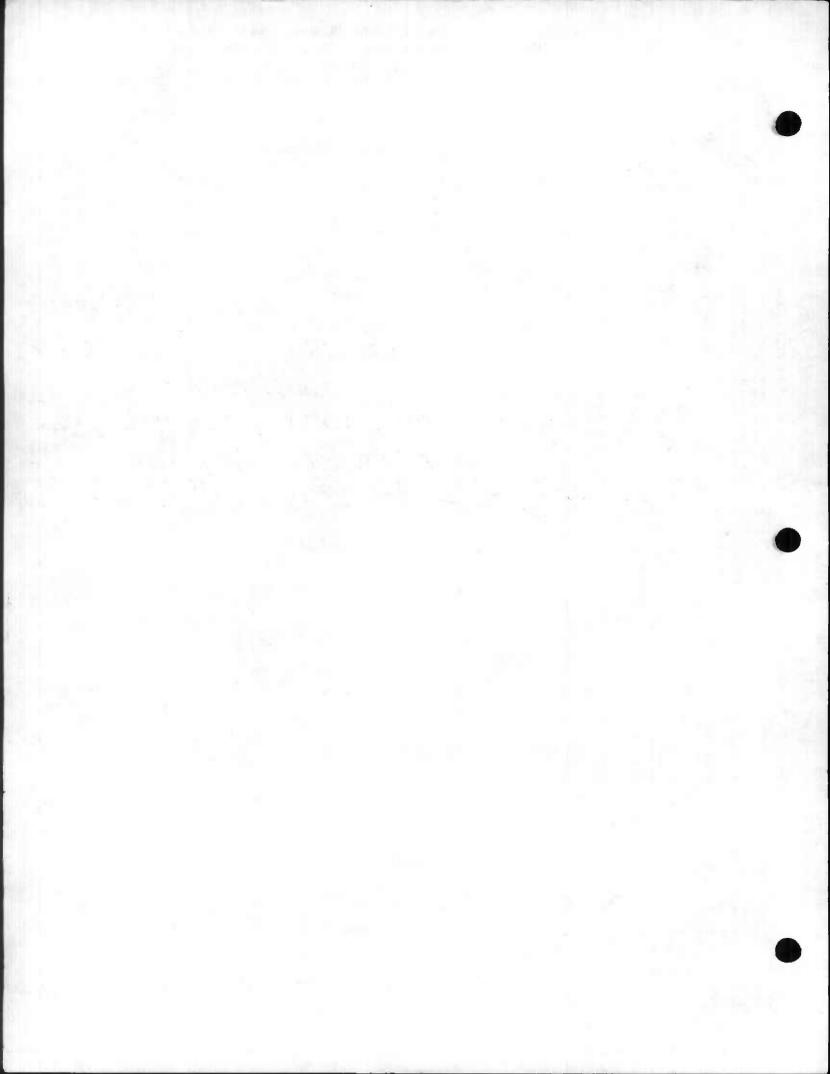
3 ☐ Suicide

29a. Certifier

Medical

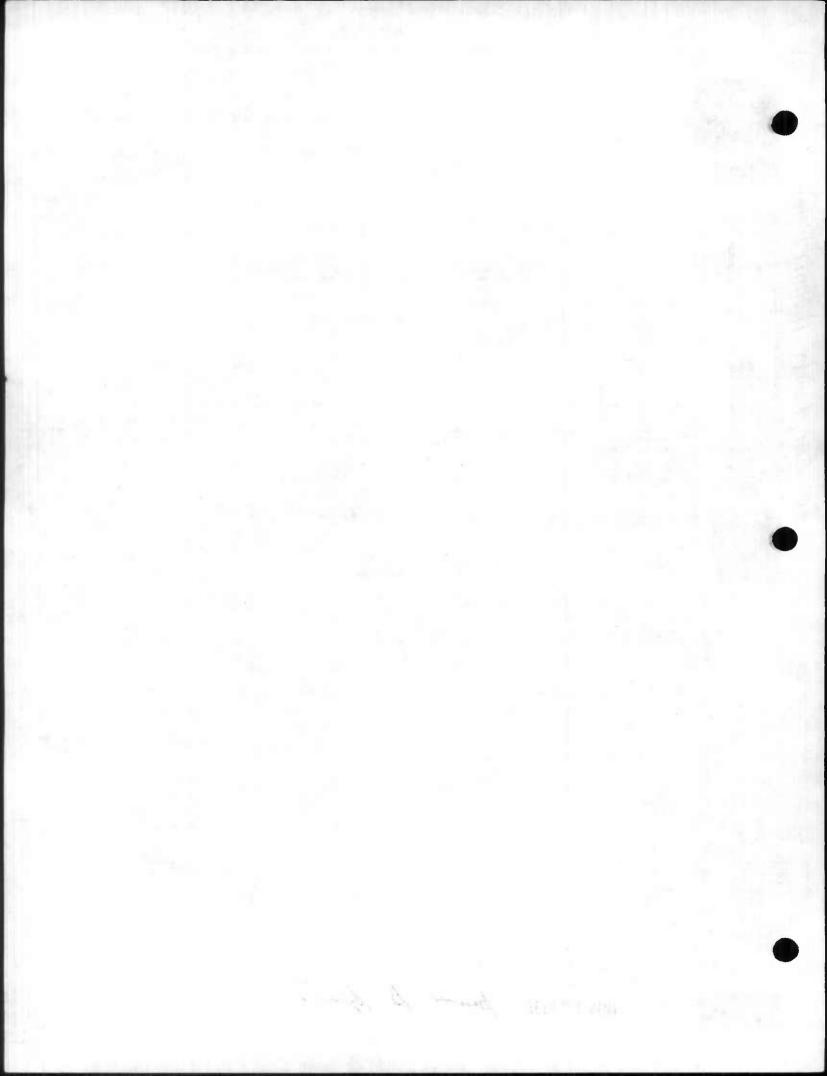
4 Homicide

32. Registrar's Signature



Piease Type or Print in Biack Indeiible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Dav Month Year **Physician** Adeline SSett ith November 12,1999 /Medical 4a Facility Neme (tf not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore Baltimore Gilchnst Center ff Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 9. Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 200 F Months 9-12-7952 Yrs. Director march 18,1925 maryland Usual Rasidance of Decedent 10a Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Baltimore Itimore 28a-f1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or itsms 23s or 212 hepherd Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Amarican Indian, 11 Meritel Status Black White etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 X No If Yes, Giva 1 ☐ Yas 2 ☐ No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) 88 Pages 1 and 2 should be nent of Health and Mental 10 O. Birkelier da E. Simonsen Justav 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Important: If Item 27 is any injury or other trau Baltimore, manuand 7840 Shepherd Ave. Nicholas T. Bassetti-Spous Baltimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata NOV. 10, 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore Mayland bardens of Faith 1999 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Evans Chapel of menones Road Harford 23a. Part1. Entar tha disaase, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. 21234 Approximata tritervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final 9 months ULVAY CANCER disaasa or condition resulting in death) Examiner Dua to (or as a consequance of) Examiner physician and the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initieted evants resulting in death) Last Dua to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) esn Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was casa refarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Mothar (Specify) Cospice 1 Yas 2 Kolo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 1 Natural 5 Panding deeth. 1 ☐ Yas 2 ☐ No investigation 2 Accidant To the Hospital or Attenwithin 24 hours after deet To the Euperal Director: 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) sempletely liked in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and file of certifier 29c. Licensa number 29d. Deta signed (Month, Day, Year) November 13, 1999 uno 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. 32. Regityary Signature State Registrar



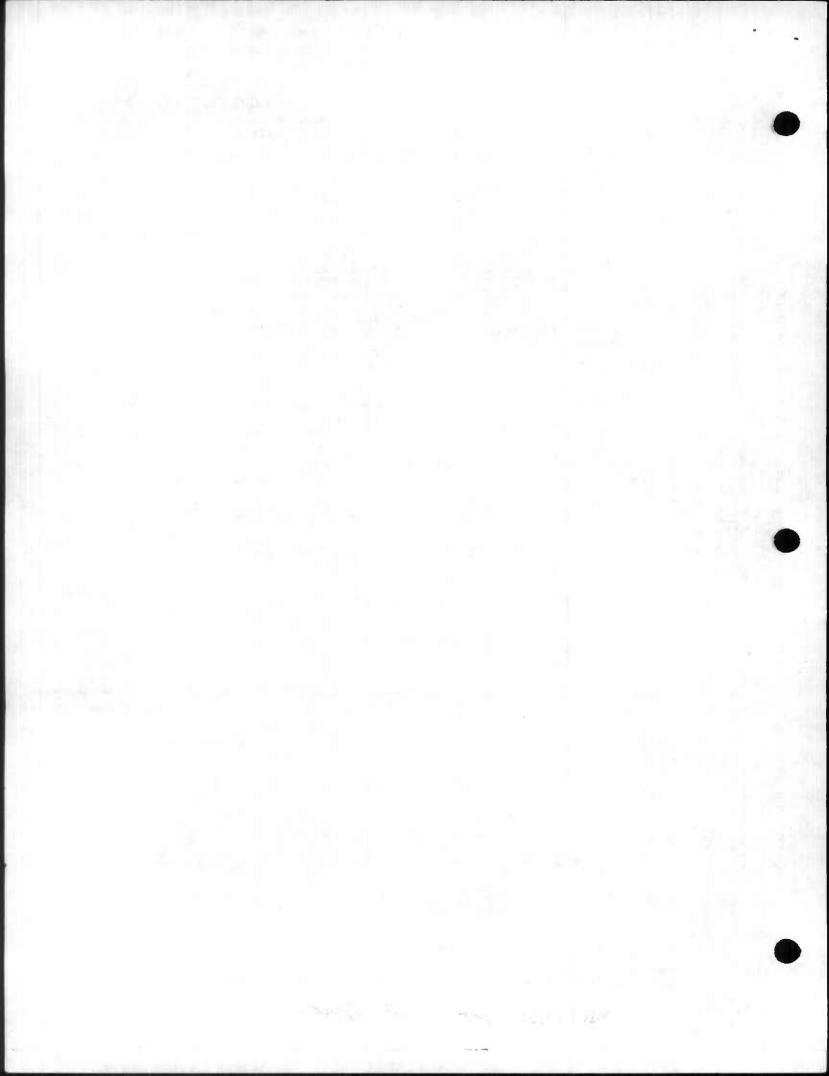
## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 99 36017

				Certificate of Death	Reg. No.	30011							
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	h	2. Dete of Deeth	3. Time of Deeth							
	/Medic Examin		Katherial E. Bachmann  4a Facility Neme (If not institution, give street and number)  Saint Joseph Medical Cente	4b. City, Town, or I	ocation of Death 4c. County of	4c. County of Deeth Baltimore							
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 M 2 X F  7. Age (In yrs. last birthday)  Months Deys Hours Min.  8. Date of Birth  Month, Day, Year)  9. Birthplace (State or Foreign Country)  MARY AND MARY A										
altimore, Maryland 21215-0020	Pages 1 and 2 should be filed within 72 trours after death witherful Hygiens. Instit if item 27 is marked other than "natural", or thems 23s unty or other traumatic event, the Medical Examiner mant.	To Be Completed by Funeral Director	10e. Street and Number  4006 Hamilton AV.  11. Merital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  17. Fether's Neme (First, Middle, Last)  19e. Informent's Neme/Relationship (Type, Pint)  19e. Method of Disposition  20e. Method of Disposition  20e. Method of Disposition	96. Mailing Address (Street and Number or Ru 3419 NOR YWWIND I	Black, Specify: 1  king 16b. Kind of Busin  MC MU  ne (First, Middle, Maiden Sumeme)  LULL BLOW	American Indian, White, etc.  White  Description  May 21234							
B	Physician /Medical Examiner		23a Part F Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,  Immediate Cause (Finel disease or condition resulting in death)  Due to (or as e consequence of):										
Division of Vital Records, P.O. Box 68760,	the death certificate be executed y the attending physician and ached for use as the burlal-transit	e Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or es a consequence of):  Due to (or es e consequence of):  d.										
	es that igned b		Part II. Other significant conditions contributing to death but not resulting PERIPHERAL VASCULAR DISEASE		probably 4 Unknown  24b. Were eutopsy findings available prior to completion of cause								
	The law ate has t page 2 s		Of Western stored to media.		1□ Yes 2√No	of deeth?							
	fing Physicis n. After this cert funeral direct	Certification: To Be		Time of Injury et Work?  M 1 Yes 2 No	Home 5   Residence 6   Other (Specify)     28d. Describe how injury occurred     28f. Location (Street end Number or Rurel Route Number, City or Town, Stele)								
	Hospi 4 hou Funer tely fill	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner steled.										
	within 2 To the complei	2	29b. Signature end title of certifier	29c. License number D30263		29d. Date signed (Month, Dey, Year)							
	NA		30. Neme and address of person who completed cause of death (flem 23a) (Type, Print) FRANCIS KHOO, M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204										
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	& South									



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Vaar BAUM AN N 7:30 NOVEMBER 10,1999 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE HOPKINS JOHUS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAR. 9, 1918 Birthplace (State or Foreign Country) Days Months 1X M 2 F Hours 112-03-8393 81 NY Usual Residence of Deceden 10c. City. Town or Location 10b. County 10d. Inside City Limits BALTIMORE OWINGS MILLS 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12104 VELVET HILLS DRIVE 21117 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 (ŽÍ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RAY

PRINCIPAL

BAUMANN

WHITE

HOWELL

MD 21208

Approximate Interval Between Onsat and Death

MONTHS

5 DAYS

3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

1 Yes 2 No

Specify

18 Mother's Name (First Middle Maiden Sumema)

12104 VELVET HILLS DRIVE - OWINGS MILLS, MD 21117

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

ESTELLE

16b. Kind of Business/Industry

**EDUCATION** 

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

1 Nevar Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

**HERMAN** 

17 Fathar's Nama (First Middle Last)

19a. Informant's Name/Relationship (Type, Print)

DIANA BAUMANN / WIFE

**Funeral** 

Director

must be notified at

28a-f

23a or

Herna

ò

Hygiene.

of Health and Mental Item 27 is marked of

8

Department of Important: If

Director

Funeral

à

Completed

88

with the Maryland

Pages 1 and 2 should be filled within 72 hours after

21215-0020

altimore, Maryland

pue physicien the USB 88 signed by I page 2 should peeu has certificate funeral director this After after deeth. the

The lew requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital Attending Physicien: Examiner Physician/Medical þ Completed Be

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 BALTIMORE HEBREW CEMETERY 11/14/99 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. West 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): THROMBUSIS CAVERNOUS SINUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number faar, MD RES-000 JOVEMBER 12, 1999

WWII

College (1-4or 5+)

29d. Date signed (Month, Dey, Year)

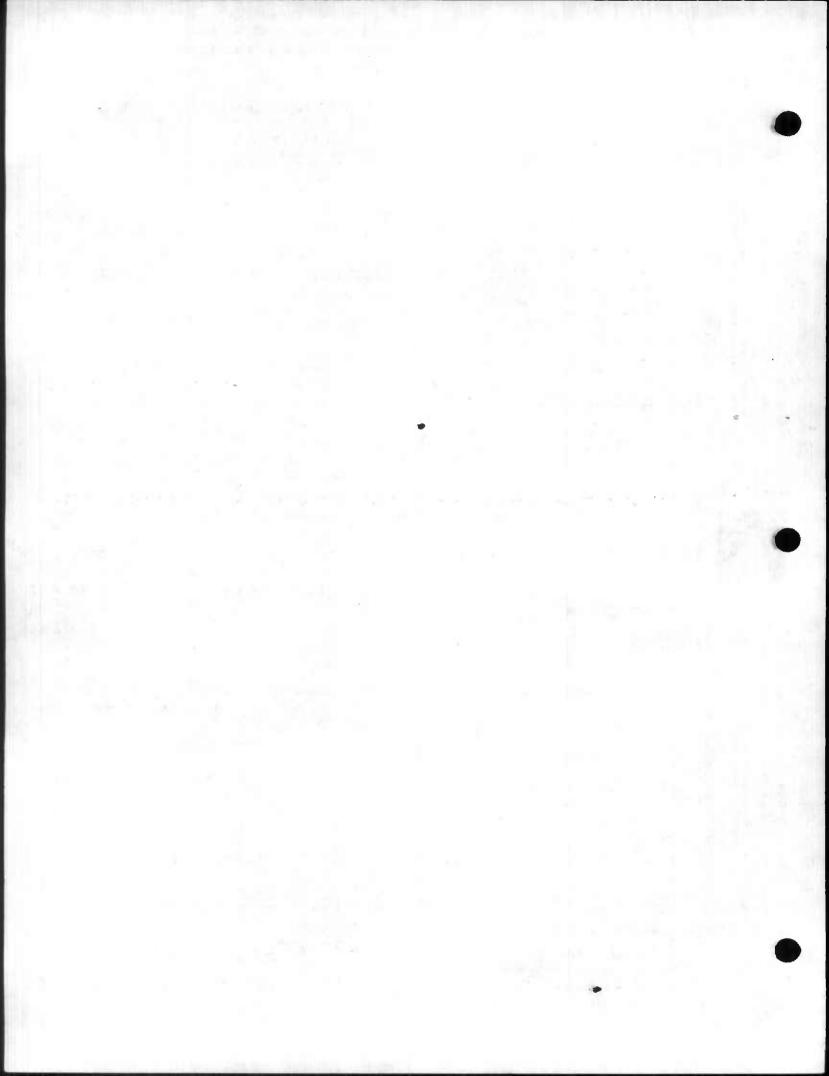
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

JOHNS -HOSPITAL, BALTIMORE, MARYLAND 21287 CM, CAAS HOPKINS DAVID 32. Registrar's Signature

State Registrar

**DHMH 16 Rev 6/95** 

2011



6 items 23s filed within 72 hours after death 21215-0020 "natural", or Baltimore, Maryland 1 and 2 should be Health and Mental Pages 1 and 2 should

Benceh, Leonord

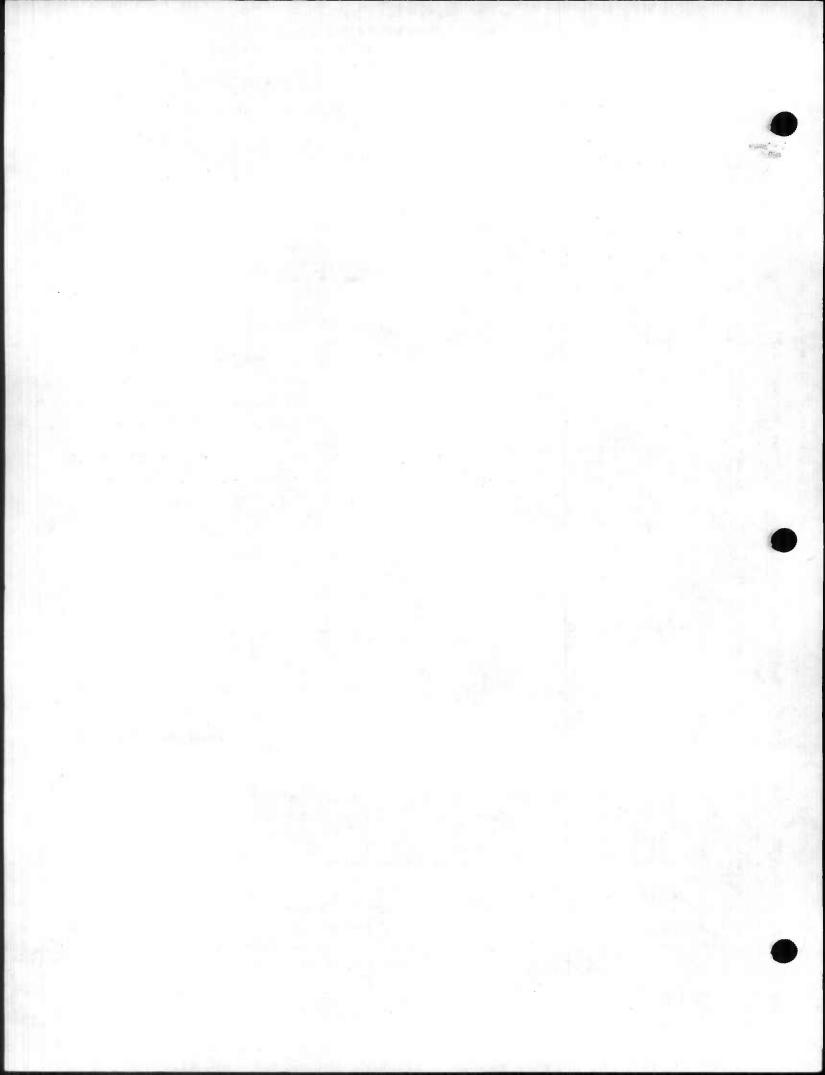
physicien and s the burial-trensit the death certificate be executed signed t should should has certificate director, this funeral After death.

Box 68760, Records, P.O. Division of Vital Attending Physician: ð Hospital

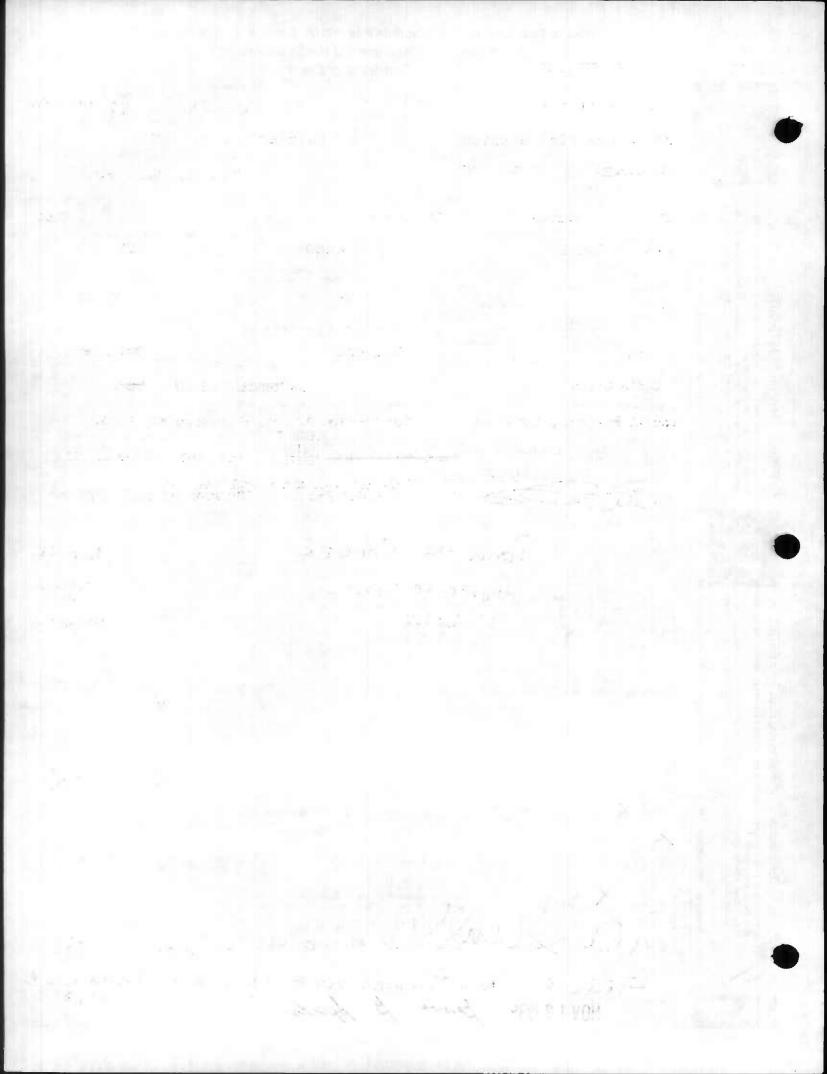
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Day Month Year **Physician** LEONARD BENESH 2:41 A.M NOVEMBER 14 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMO12E SINAL HOSPITAL N/A/ If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year 8. Dala of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Funeral Months Days Hours 212-16-9811 10XM 2□ F Director 80 DEC.5,1918 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6402 APOLLO DRIVE #C 21209 U.S.A. Funerai 12. Was Decedent Evar in U,S. Armed Forcas? 1 X Yas 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc 1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 X No Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Department of Health and Mantal Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Ma Pace. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RETAIL CLOTHING 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middla, Last) Be HARRY н. BENESH LEAH **GOLDMAN** 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) ADELE BENESH / WIFE 6402 APOLLO DRIVE #C - BALTIMORE, MD 21209 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata CHIZUK AMUNO ARLINGTON 11/15/99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signatura of Juneral Service Licensee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) MULTI SYSTEM ORGAN FAILLIZE Examiner Due to (or as a consequence of): Examiner GASTRO INTESTINAL Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANOXIC BRAIN INJURY ģ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 No Be 25. Was casa referred to medical 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding n 24 hours efter death.

• Funeral Director: A pletely filled in by the fi 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicida 29a. Cartifiar edicai 餐 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) V A52402321 MN2950 non montgom NOVEMBER 14, 1999 VVD 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) 0 6508 SANZO BALTIMORE, MD ROAD Z1209 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State NOV 17 Registrar

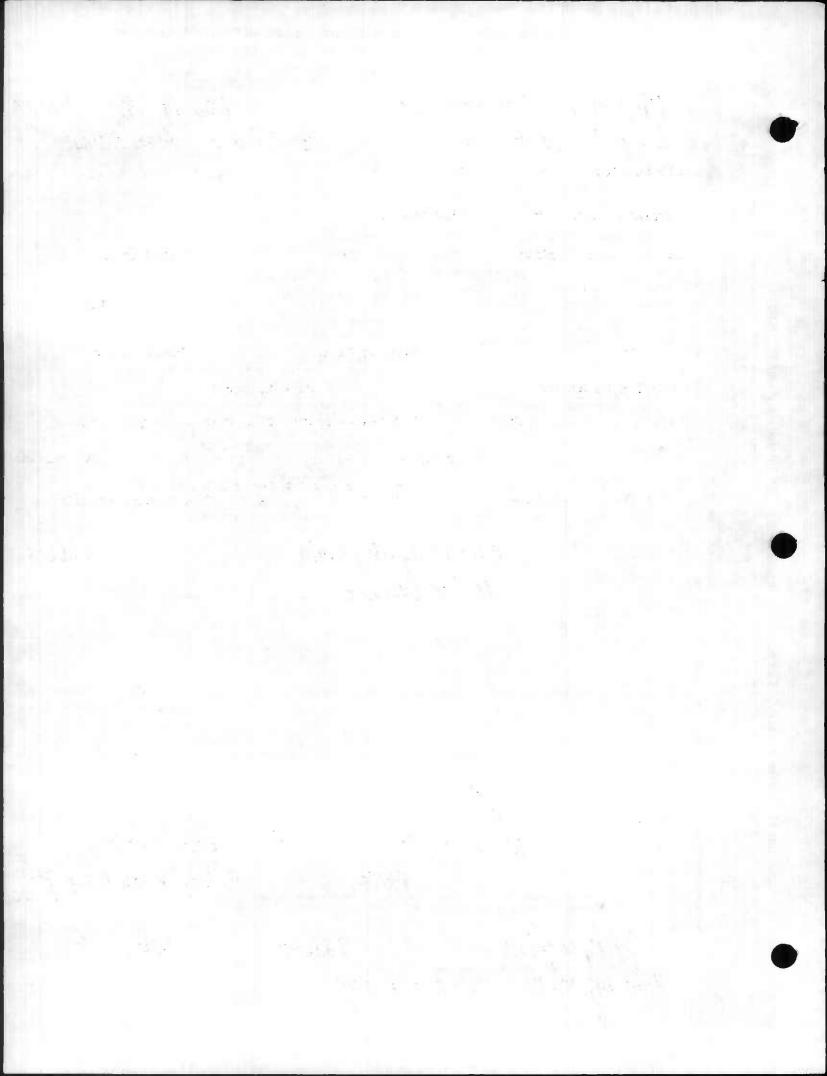
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



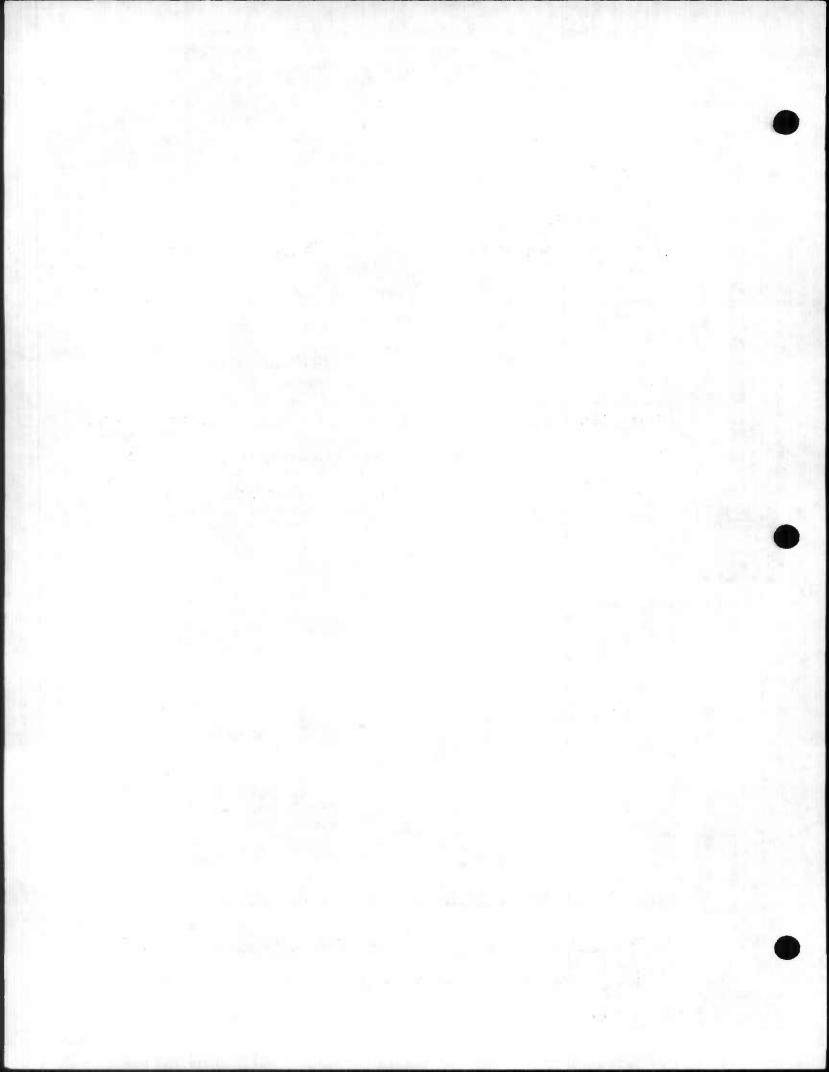
	1. Decedent's Neme (First, Middle, L	ast)				2. Dete of Deeth Month	Dey	Year	3. Time of Death	
nysician Medical	Susie Bell Be	oyd				VOV-en ber		99	10.53 Am	
kaminer	4e Facility Neme (If not institution, g				4b. City, Town, or Loc		4c. County			
	Union Memoria  5. Social Security Number 6.		call ge (In yrs. last birtho		Baltimore	_	N/A		ce (State or Foreign	
neral ector	213-26-3435 Usuel Residence of Decedent	1□ M <b>%</b> C/F	77 Yrs	Months Days	Hours Min.	8. Dete of Birth (Month, Day, Ye Feb. 12,	1922	Countr	ce (State or Foreign y)	
any injury or other traumatic event, the Medical Exeminer must be notified at once.  To Be Completed by Funeral Director	10e. Stete 10b. County		10c. City, Town o	r Location				100	d. Inside City Limits	
tor	NC War	ren	Litt1	eton					1 ☐ Yes XX No	
al Director	10e. Street end Number Route 3, Box 82			10f. Zip Code 278	350	10g.	Citizen of W	/het Countr SA	y?	
by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Yeer or Detes:	No	I3. Was Decedent of In Yes, specify Cub	Hispenic Orlgin? (Specien, Mexican, Puerto R	oify Yes or No- lican, etc.)		- Americe k, White, et Bla	tc.	
Be Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4or	5+)	ecedent's Usuel Occu live kind of work done e. DO NOT use retire Homemaker	pation during most of working ad)	g 16b	. Kind of Bu	siness/Indu		
e Co	10 17. Fether's Neme (First, Middle, La.	ost)			18. Mother's Name	(First, Middle, Maid				
OB	Eddie Green				Georgin	a GREGOR'	/ <del>U</del>	nk.		
	19a. Informent's Neme/Reletionship				t and Number or Rural			State, Zip C	Code)	
	Wendell Baylock	/ Grandson	OOL Disease Of D	innacition (Alama of	Avenue, I		MD Location -	21206		
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion   4 ☐ Donetion 5 ☐ Other (Spec		cemetery,	crematory or other pla	ICE) TION	ov.20,1999		letan,		
Opce	21. Signature of Funeral Service Lic	ensee Victor P	. Doda, Jr.	Charles L. 1501 Fast F	ess of Fecility Stevens Funer ort Avenue, E	al Home, I altimore	nc. Marylan	nd 21	230	
a al a la al a la al a la al al al al al	23a. Pert1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		Due to (or es e cor	CANCE				(	month.	
Exa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	7:	a be tes	nsequence of):					NAME.	
/Medical Examiner	Ceuse (Disease or injury that initieted events resulting in deeth) Lest	c	Due to (or es a cor	sequence of):					Steam.	
y Physician/M	Pert II. Other significant conditions	contributing to death	but not resulting in th	ne underlying ceuse g	iven in Pert f.	23b. Did tobe	2 No	atribute to	the cause of death?	
Completed by						24a. Wes en e performed	utopsy 1?	evei	re eutopsy findings ilable prior to apletion of cause eeth?	
dwo						1 ☐ Yes	al No		Yes W No	
BeC	25. Was cese referred to medicel				26. Place of Deeth		1		N	
To B	examiner? 1 ☐ Yes 2 No	Hospital: Inpat	ient 2 ER/Outpa	atient 3 DOA	hor	ne 5 Residenc	e 6 □Oth	er (Specity,	)	
ation:	27. Menner of Deeth  1 Natural 5 Pending 2 Accident investigat		jury 28b. Tim ay Year) Inju	ry Wo	ork? ] Yes 2 □ No	8d. Describe how	injury occur	red		
edical Certification:	3 Suicide 6 Could not determine	d 286. Piece of it	njury - At home, farm etc. (Specify)	, street, factory, office	2	8f. Location (Stree City or Town, S	t end Numb itete)	er or Rural	Route Number,	
dical			of examination end/o		ime, dete end plece, e opinion, deeth occurre					
Medical Certification: To Be Comp	29b. Signature and little of certifier	111	MARI	1	nse number 4389 46 - A		Date signe	d (Month, D	Day, Year)	
										í



dece		State of Marylan		tment of F ificate of			giene 9 9 Reg. No.	36021
Physician /Medical	1. Decedant's Nama (First, Middle, Last MIChael A	Broseker	Sr			2. Data of De	1 74 198	3. Time of Death
Examiner Funeral	4a Facility Nama (If not institution, giva  5. Social Security Number  6. Se	Hospital x 7. Age (In yrs.	lest birthday)	If Under 1 Yaar	4b. City, Town, or Lo	8. Date of Bir (Month, De	Anne	Arundel Birthplace (State or Foreign Country)
Director	219-80-5104	3M 2□ F 39	Yrs.	Months Deys	Hours Min.	Aug.		Maryland
r 28a-f show noutled at	10a. State 10b. County Maryland Anne Aru		y, Town or Loca Burnie					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
a or 28a or 28a it be not	10e. Street and Number 119 S. Jerome Park	way		10f. Zip Code 21060			10g. Citizen of Whe	
5-0020 72 hours after death with the Maryland netural; or items 23s or 28s-f show stell Examples must be notified at sted by Funeral Director	11. Marital Status  1 □ Navar Marriad 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:			dispanic Orlgin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Americen Indien, Whita, atc. White
D = 1	15. Decedant's Edu (Specify only highest grad Elementery/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give ki life. Do	nt's Usuel Occup ind of work done O NOT use retire	during most of work d)	ing	16b. Kind of Busin	
yland 212 Mental hygiene, wheel diport that after event, treat To Be Completed.	17. Father's Nama (First, Middle, Last) Charles L. Brosek	er	ыптррі	ing cier			, Maidan Surneme)	CION
Marylar Ind 2 should b alth and Menta 27 is marked r traumatic ex	19a. Informant's Name/Reletionship (T) Sandra L. Broseker				and Number or Run	al Route Numb	er, City or Town, Ste	
More,	20e. Method of Disposition  1 ☑ Surial 2 ☐ Cremetion 3 ☐ F  4 ☐ Opnetion 5 ☐ Other (Specify)	teniovei irom State	Plece of Disposi emetery, crema	ition (Neme of atory or other ple 1 Cemete	ce) N	Date Nov. 18	20c. Location - City	
Balti permit. Departm Importa any inju	21. Signature of Funeral Servino Licens		Kir		ddick Fun		ome, P.A.	MD 21061
requires that the death certificate be executed requires that the death certificate be executed expension and inhould be detached for use as the bunal-transit eted by Physician/Medical Examiner	Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	C	or as a consequence of	ence of):	?12			12 hours
P.O. BOX 6 hat the death certific d by the attending felached for use as Physician/Me	Part ff. Other significant conditions con	ntributing to death but not rest	ulting In the unc	derlying cause gir	ven in Pert I.			bute to the ceuse of death?  Probably 4 Unknown
He law						perfe	s en autopsy primed?	24b. Were autopsy findings availabla prior to completion of ceuse of death?  1  Yes 2 No
Vita icleni certifi rector	25. Was case referred to medical exaginer?	lospital:	FD/0 4	o Double	26. Plece of Deet			70
After fune	27. Menney of Death  1	28a. Dete of Injury  (Month, Pey Year)  28e. Place of Injury - At he building, etc. (Specifi	ER/Outpatient  28b. Time of lajury  pme, ferm, streety)	28c. Inju Wo 1	ry et rk?	28d. Describe  COCAI  28f. Location (	how injury occurred  NO OVER  Street end Number own, Stete)	1050 or Rural Route Number.
		sicien: To the best of my kno- ner: On the basis of examine and menner stated.						
To the within to the comp	290. Signature and title of certifier  Physics Pugg	W (M		29c. Licens	01 110		29d. Date signed (A	Month, Dey, Year) 5; 1999
	30. Name and advision of berson with the 2414 Hahree	mpleted cause of death (Item  1 COHON	23e) (Typa, P	21114				
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signe	gure G.	Spark	N			

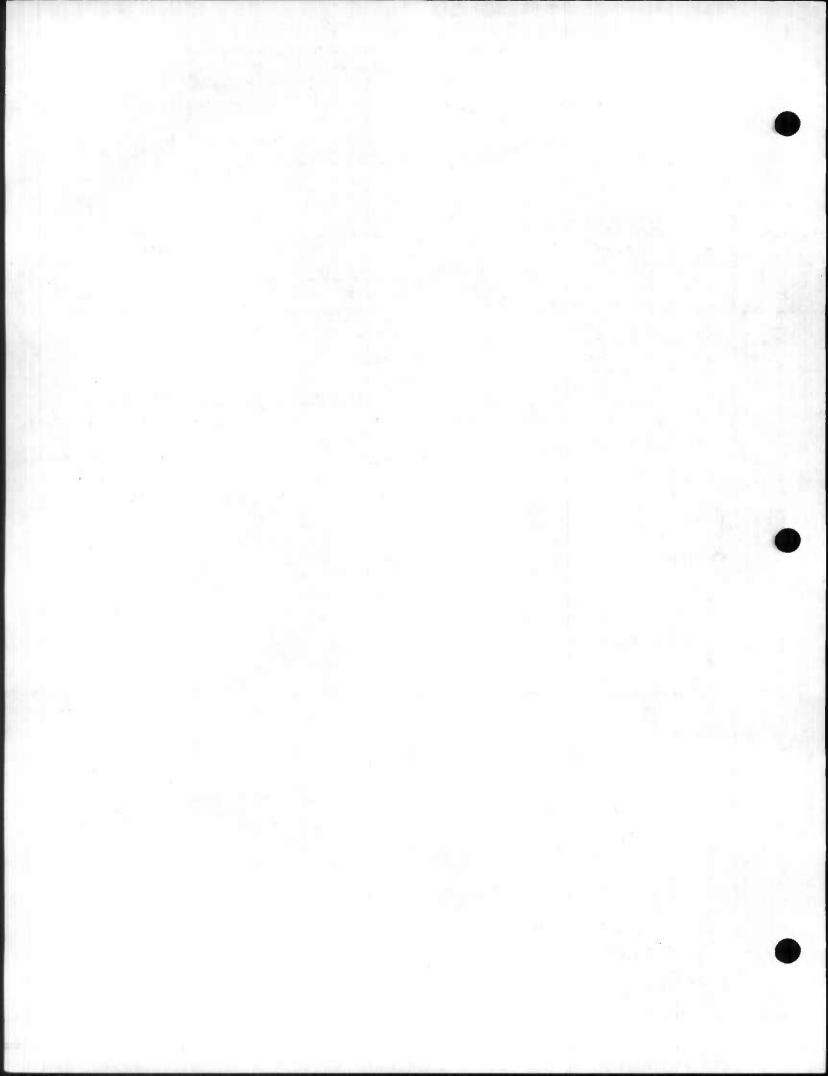


			State of Mary		rtment of F tificate of				9 3	6022
1	Physician	Decedent's Nama (First, Middla, Las  JULIA	it)	В	LOOM	-	2. Data of Death Month NOVEMBER		Year	Tima of Death 5:37 AM
	/Medical Examiner	4a Facility Nama (If not institution, giva 725 MT. WILSON L.			4	BALTIMO	ocation of Death	4c. County of BALTI	f Death	
	Funeral Director	5. Social Security Number 6. Se 215–09–0850	The ATTE	yrs. last birthday) 93 Yrs.	ff Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Y OCT.19, 1	(ear) 1906	9. Birthplace Country)	(Stata or Foraign MD
	death with the Maryland ms 23s or 28s-! show caust be notified at neral Director	Usual Rasidance of Decedant  10a. Stata 10b. County  MD BALTIMO		BALTIMOR						Inside City Limits 1 ☐ Yas 2 🖔 No
	death with the Maryta ms 23s or 28s-f show cmust be notified at neral Director	10e. Street and Number 725 MT. WILSON L			10f. Zip Code	21208	τ	J.S.A.		
020	af, or its Examins by Fur	11. Marital Status  1 Nevar Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Datas:	If	/as Decedent of H Yas, specify Cuba ☐ Yes 2 XNo	ispanic Origin? (Si an, Mexicen, Puarti Specify:	pecify Yes or No- p Rican, atc.)		- American I , Whita, atc.	ndian, VHITE
Maryland 21215-0020	ed within 72 hours after ygiene. or than "natural", or ha it, the Medical Examine Completed by Fu	15. Decedent's Ed (Specify only highast grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Giva k	O NOT use retired	during most of wor	king	16b. Kind of Businass/Industry  OWN HOME		
/land	should be filed nd Mental Hygin marked other umafic event, til To Be Co	17. Father's Name (First, Middle, Last) DAVID		HEYMA	N	18. Mother's Nam MOLLIE	na (First, Middla, Ma			NBERG
	and 2 sho ealth and in 27 is me her traums	19a. Informant's Name/Ralationship (7 MARILYN BLITZ / 1	DAUGHTER	1725	YORK AVE		ral Routa Number, 0 E - NEW YO	ORK, NY	10128	3
Baltimore,	mit. Pages 1 partment of H portant: If Ber y Injury or off ca.	20a. Mathod of Disposition  1 XBurial 2 Cramation 3 4 Donation 5 Othar (Specify	Removal from Stata	Ob. Place of Dispos cematary, crem CHIZUK A	atory or other place			BALTIM		
Ball	Departi Departi Importi any inj 2059.	21. Signature of Funeral Bende Licens	Lower	8		TERSTOWN	SOL LEVI ROAD - PI	IKESVIL		
	Physician /Medical Examiner	23a. Part 1 Enter the disease, or companied, or heart failure. List only to immediate Causa (Final disease or condition resulting in death)	Pre	MONICA to (or as a consequ		g, such as cardiac	or respiratory arras	·	Inte	proximata arval Batween set and Death
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Box 68760,	nat the daath certificate be assected dby the attending physician and letached for use as the burial-transit Physician/Medical Examin	that initiated evants rasulting in death) Last	d.	to (or as a consequ	ence of):				1	
P.O. B	that tha death ed by the atta detached for / Physicia	Part II. Other eignificant conditions co		t resulting in the un	derlying causa giv	en in Part I.				cause of death?
of Vital Records,	been sign should be						24a. Was an performe		availat	autopsy findings bla prior to stion of cause th?
ital Re	certificate has rector, page 2	25. Was casa rafarred to medical axaminar?				26. Place of Dea	1 ☐ Yas	- ' '	1 □ Ya	as 2□ No
Division of V	this aid	1 Yas 2 ANO  27. Mannar of Death 1 Natural 5 Panding 2 Accidant invastigation 3 Suicide 6 Could not be	28a. Data of Injury (Month, Day Yea		M 28c. Injur Wor 1 □	4 LI Nursing H	oma 5 Rasiden 28d. Describe how 28f. Location (Stre	injury occurre	d	outa Number,
Div	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:		building, atc. (St	knowledge, death	occurred at tha tin		City or Town,	Stata)	nar as state	d.
	To the Hospital within 24 hours of To the Funeral Completely filled	(Check only 2   Medical Exam	iner: On the basis of axar and manner stated.	nination and/or invi	29c. Licans			a and place, a		
	10	30. Name and addrass of person who o			Print)	50077	ST	BALT	MD	21230
	State Registrar	31. Data Med (Month, Day, Year)	32. Registrar's S	1111	- into	3 0 0 1 2		7,701		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Deeth Month Dey **Physician** LLOYD ROBERT BURUCKER NOVEMBER 7, 1999 10:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTWOOD ELDERCARE LUTHERVILLE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Days Months 1⊠M 2□ F 455-03-3054 86 Director JUN.12,1913 MD **Usual Residence of Decedent** the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 1 Yas 2 No MD BALTIMORE Director REISTERSTOWN notifie 10e Street and Number 10f. Zip Code 10o. Citizen of What Country? must be a 18 BROOKEBURY DRIVE 21136 U.S.A. Funeral therms: 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ 3⊠ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 IRON WORKER STEEL Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental HARRY LANGLEY BURUCKER ADA MACNEAL 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a if flem 27 is or other tra ROBERT LANGHORNE BURUCKER / SON 11960 PARK HEIGHTS AVENUE - OWINGS MILLS 21117 20b. Place of Disposition (Name of cemetery, cremetery or other place) RDENS 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/9/99 DULANEY VALLEY MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) TIMONIUM, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each tine. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) days polomenia Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last and Due to (or as a consequence of): Box 68760 physician Physician/Medical the Due to (or es a consequence of) US0 88 signed by the atte Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed After this certificate has page 2 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: A Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ENetural after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital of within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) 29b. Signature and title of certified 29d. Dete signed (Month, Dey, Year) 29c. License number mo NOU. 8, 1999 051426 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Pikesville, MD 21208 Rethschild 4000 old Court Elliot 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State NOV 16 1999 Registrar ooks!

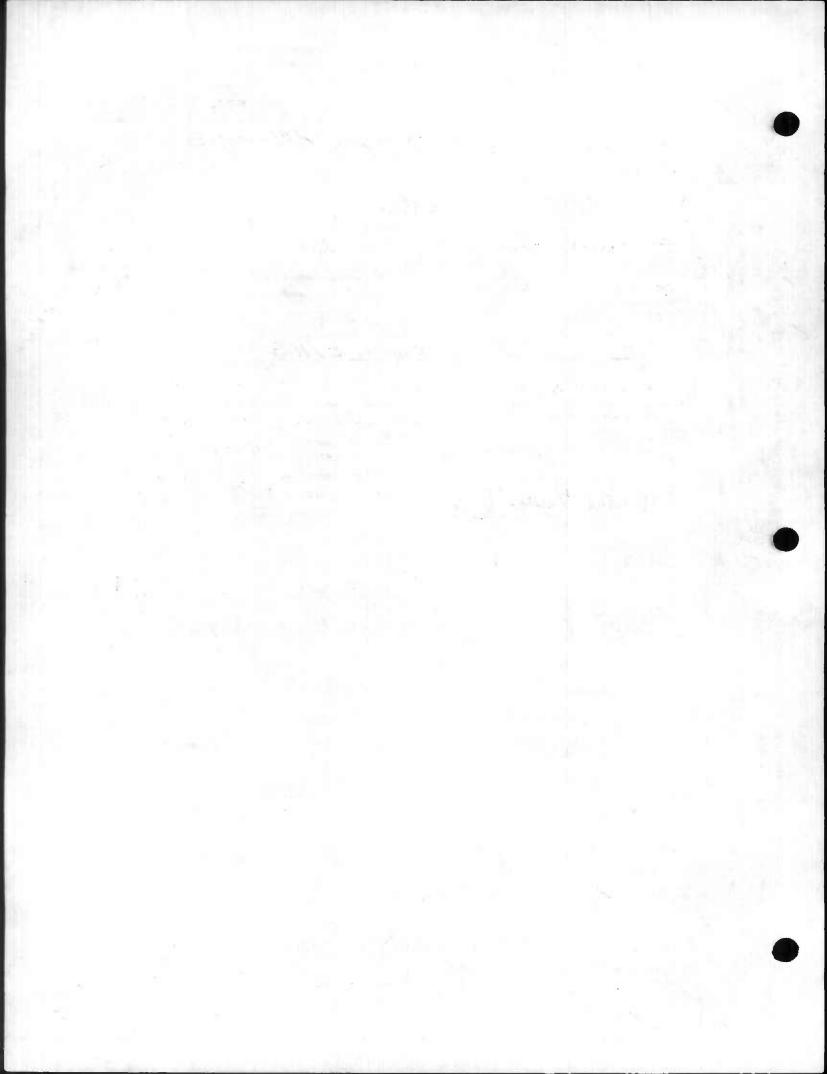


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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day WESLEY BRANCH D. November 13 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MERCY HOSPITAL hospice BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 10 M 20 F 217-80-2496 38 SEPT.19,1961 MARYLAND **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3435 JUNEWAY 21213 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Never Married 2 Married 1 Yes 2 No If Yes, Give A Year or Dates: AFRO-AMERICAN 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary 11TH condary (0-12) College (1-4or 5+) N/A DISHWASHER FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) TOMMIE F. BRANCH MAUDE SCOTT 19a. Informent's Name/Relationship (Type, Print) SISTER LAVERNE MC CAFFITY-WARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3435 JUNEWAY BALTIMORE, MD. 20b. Place of Disposition (Name of cametery, crametory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEM. PARK NOV.18,1999 BALTO, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 21213 Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) uno En ortz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 Yes 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specifity > ) NIV 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

physician and the buriel-transit for use as signed by the e Division of Vital Records, has page 2 certificate or Attending Physician: funeral director. this After 24 hours after death. filled in by

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Examiner

**Physician** 

/Medical

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Baltimore, Maryland 21215-0020

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31. Date filed (Month, Day, Year) State Registrar

Medical

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

5 Pending

investigation 6 ☐ Could not be

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

301 St PM D1

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D40854

Bulding 1MD 21202

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year) 15

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#16a PER F. H. G777 11-17-99 J.A. 1. Decedent's Nama (First, Middle, Last) Certificate of Death 3. Tima of Death 2. Data of Death Nov 1,45 1 KOBERT MERVVN ARMSTRONE 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death GILCHRIST CENTER TOWSON BALTIMORE CO If Undar 24 Hrs. 8. Data of Birth Hours Min. Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthpleca (Stete or Foraign Caustry) M 2□F Days Months 206 - 20 - 3/38 Usual Rasidence of Dacedant 10c. City, Town or Location 10a Stata 10h County 10d. Insida City Limits 1 Yas 2□No N MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21202 D.5.A 51 1001 ALICEANNA 12. Was Decedant Evar in U,S. Armed Forcas? 1 M Yas 2 □ No M Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, atc. 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: 3 ☐ Widowad 4 ☐ Divorced WHITE WWI 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) CHURCH EREYMAN CLERGYMAN 5+ 18. Mothar'a Nema (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) ARMSTRONE ELVINA ICHARD M. E. BURNS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) BALTO, MD 21202 PRISCILLA 1001 ALICE ANNA ST W. ARMSTRONE 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition NOV.15 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) METRO CREMATUR LTO. CO. 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility HUDSIN ST SKARDA 23a. Part1. Enter the disease, of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in death) Concer RAYS Due to (or as a consequence of) Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings availabla prior to complation of cause of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Chack only ona) Other: 4 | Nursing Homa 5 | Rasidanca 6 Millothar (Specify) HOS pice 1 Yas 2 No Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending invastigation 1 Yes 2 No 2 ☐ Accident 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 - Homicida

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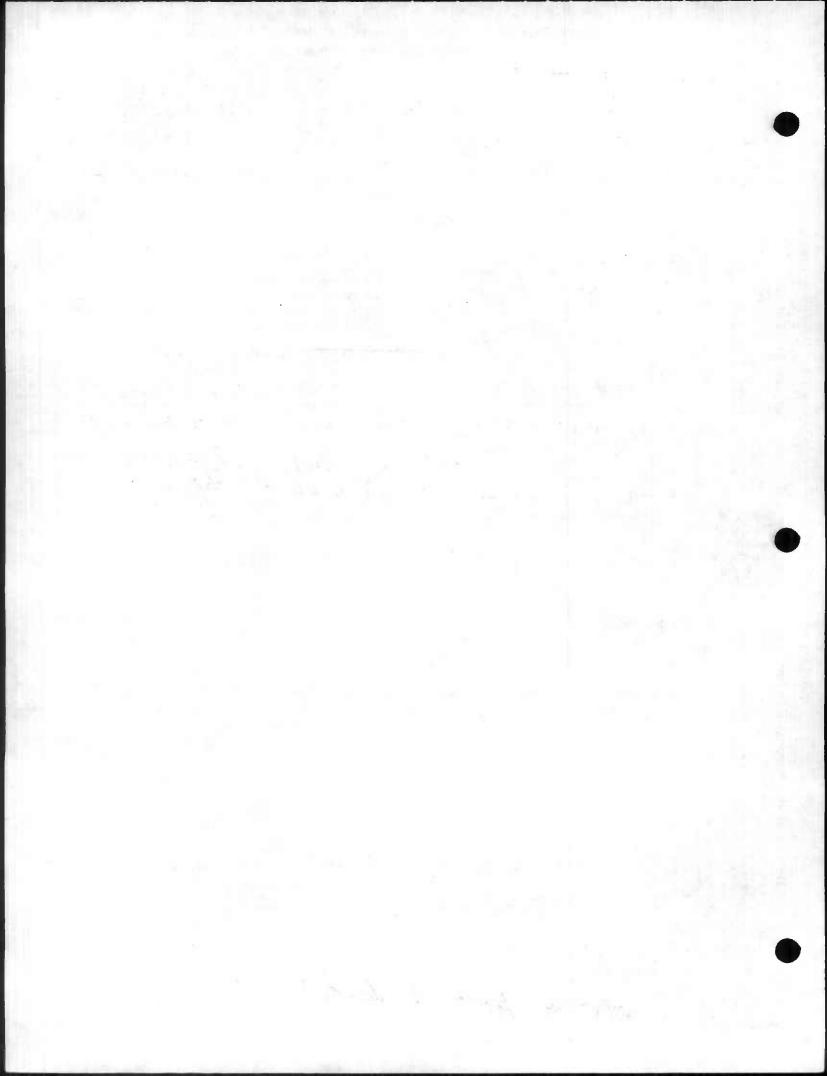
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1/2 Certifying Physician: To tha best of my knowledge, death occurred at tha time, date and placa, and dua to tha causa(s) and manner as steted.

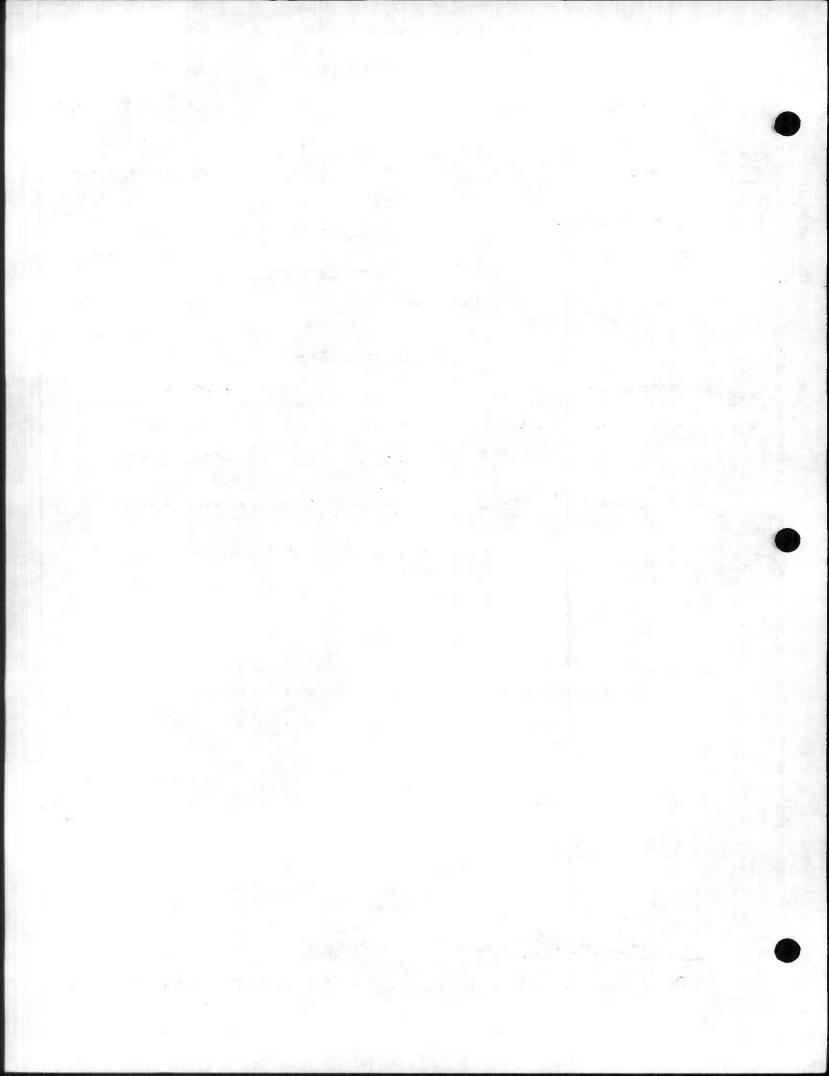
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29d. Data signad (Month, Day, Year) November 14, 1999

BALto md 2120x



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	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)		Arter	ioscl	erotic	Cardiov	ascular	Disease		10	) years
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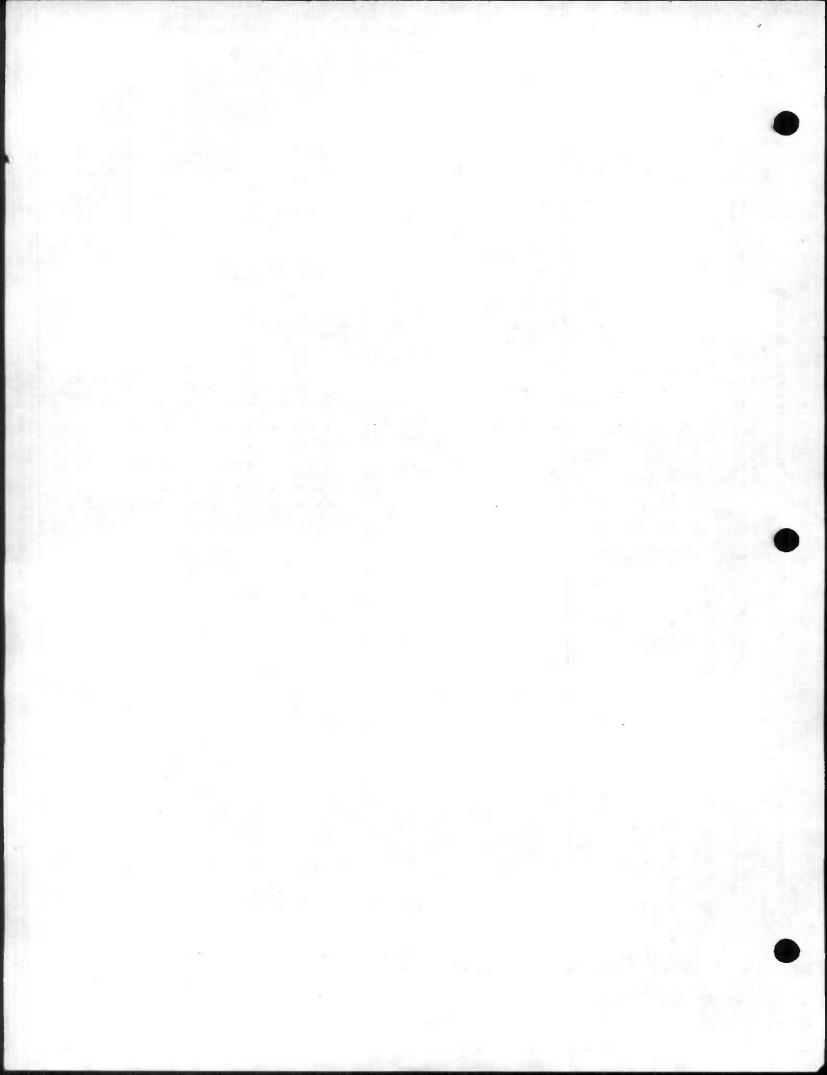


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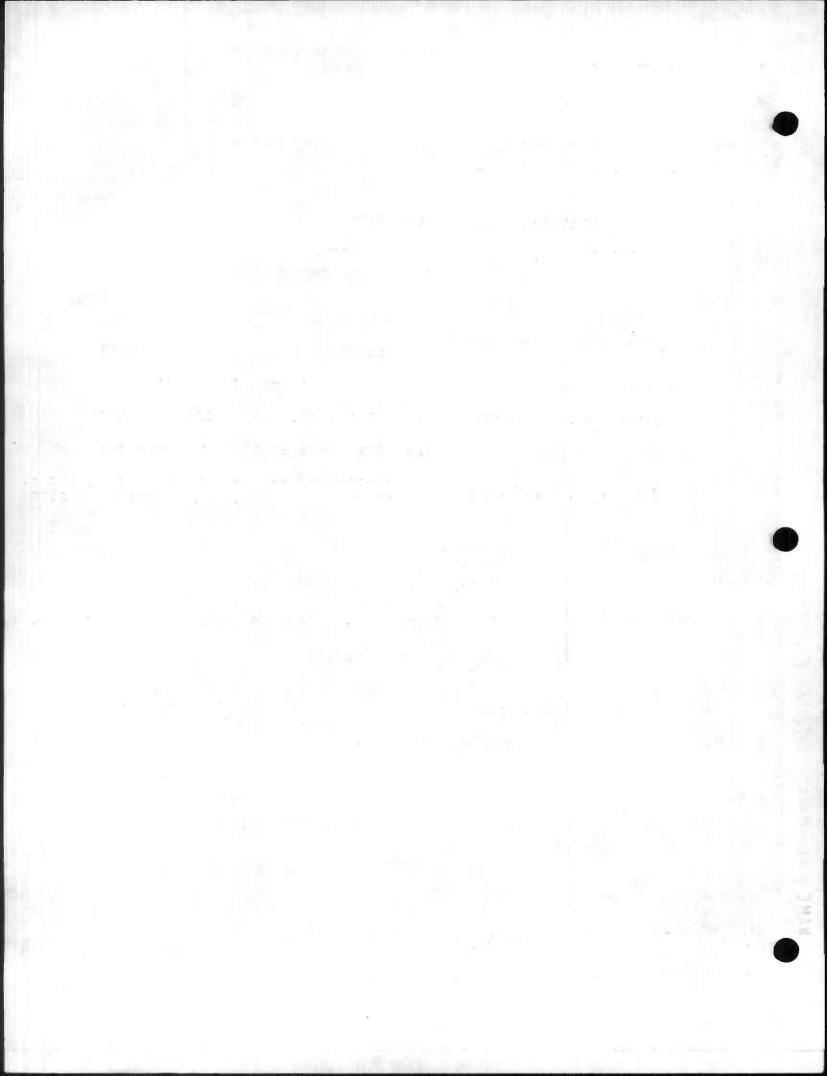
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	BERT	AMEND ITEMS: #2:	State of Marylar 3 PART I. 27	nd / Department of	Health and Mental		36028
RU	RKHARDT	Decedent's Name (First, Middle, La		) Certificate of		Reg. No.	3. Time of Death
	Physician	Dohowt 7	oseph Burk	hardt	NOVE		Year 9 5:30P.M.
	/Medical Examiner	4a Facility Name (If not institution, give		marut	4b. City, Town, or Location of		
		716 WASHINGTON PI	LACE		BALTIMORE		
	Funeral Director	5. Social Security Number 6. S	hDM 2□F	Months Days	Hours Min. (Mon	th, Day, Year)	9. Birthplace (State or Foreign Country)
		213-32-9055 Usual Residence of Decedent	64		Augus	st 28, 1935	Maryland
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	r fems 23s from must	716 Washington Pi	12. Was Decedent Ever in U	21203	L Hispanic Origin? (Specify Yes ban, Mexican, Puerto Rican, et	United	- American Indian,
0	or her		Armed Forces?  1 X Yas 2 No 19  If Yes, Give 19	52-			, White, etc.
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Maryland	d 2 should be file th and Mental Hyy T is marked othe treumatic event,	19a. Informant's Name/Retationship (	Type, Print)	19b. Mailing Address (Street	et and Number or Rural Route I	Vumber, City or Town, S	tate, Zip Code)
	of Heelth of Heelth Item 27 r other tr	Edna Alice Calime 20a. Method of Disposition	er (sister)	6902 Beech A	venue, Baltimo		nd 21206 lity or Town, State
nou		1 Burial 2 XCremation 3 4 Donation 5 Other (Specif	Removal from State	cemetery, crematory or other plant	ace)		
Baitimore,	permit. Pege Depertment of Important: If eny injury or page.	21. Signature of Funeral Service Lices	CII	esapeake Crema 22. Name and Add	ess of Facility		Lle, Maryland
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		23a. Part1. Enter the disease, or com shock, or heart tailure. List only	plications that caused the deat	th. Do not enter the mode of dy	en Pastures Dr ring, such as cardiac or respira	tory arrest,	Approximate Interval Between
	Physician	121-111-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1					Onset and Death
1	/Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	NAR	COTIC INTOX	ICATION		
	<u> </u>		Due to (c	or as a consequence of):			
	be executed sicien and burlei-transit	Sequentially list conditions	b. Due to (c	or as a consequence of):			
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6876		Bigit ministen event?	Dua to (o	or as a consequence of):			
X 6	seth certificate standing physic for use as the clan/Medic		d				
Box	the deeth certificet d by the ettending phy eteched for use as th Physician/Medi	Part II. Other significant conditions of	antibuting to death but not me	usting in the underlying source	ince in Dark 99h	Did tobacco use cont	ribute to the cause of death?
	ed by the deteche	ratu. Outer agrincant conditions c	ommouning to death but not les	onting in the underlying cause g	Per III Fait I.		3 Probably 4 Unknown
Ś	£ 55 A						
Records,	The lew requires sets has been sign, page 2 should be Completed by					. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
Sec	20 20				I,	rspection	of death?
=	yelden: The last certificate he director, page					1 ☐ Yes 2 Ø No	1 Yes 2 No
Vitai	Physicien: this certific ral director,		Hospitat:	ER/Outpatient 3 DOA	26. Place of Death (Check ther: 4 Nursing Homa 5 🛚		(Casaita)
to o	erthis eral di		28a. Date of Injury	28b. Time of P 28c. Inju		cribe how injury occurre	
ol	Attending is r death. ector: After by the funer iffication.	1 Naturat 5 Pending investigation	11_11_00			JECT INGE	STED DRUGS
	tal or Attending Pins effector: After the line by the funers Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of tnjury - At he building, etc. (Specif	ome, farm, street, factory, office fy)		ation (Street and Number or Town, State) / 1 C	
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	To the Heaptal or Attending Privation 24 hours about 52 to the Funcion Districtor. After this completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifying Ph (Check only 2 Medicat Example)	nysician: To the best of my kno niner; On the basis of examina and mannar stated.	owledge, death occurred at the tation and/or investigation, in my	ime, date and place, and due to opinion, death occurred at the	time, date and place, ar	ner as stated. ad due to the cause(s)
	Within Somple	29b. Signature and title of certifier	1	29c. Licer	nse number	29d. Date signed	(Month, Day, Year)
	1	Atunh	1 Vlas	Itano O.C.	.M.E.	NOVEMBER	12.1999
		30. Name and address of person who	completed cause of death (ften	1111			
	V	Stephen S.	Radentz		Street, Balti	more, Maryl	and 21201
	State Registrar	31. Date filed (Month, Day, Year) NOV 1 7	32. Registrar's Signa		rela!		
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AMENDE	ED ITEM # 13	PER FH G778 12/27/99 AF	State of Marylar		ment of F ficate of		-	giene 9	9 361	029
	Physician /Medical	1. Decedent's Name (First, Middle, L					2. Date of De Month Nov		Year_	me of Death
	Examiner  Funeral  Director	4e Facility Nama (If not institution, girls Stages Acadt) 5. Social Security Number 6.	ive street and number)		f Under 1 Year lonths Days	4b. City, Town, or Li Bultim If Under 24 Hrs. Hours Min.	cation of Deat	4c. County		
	Pu »	Usual Rasidanca of Decedant  10e. Steta 10b. County		ity, Town or Locati	ion				40d Inci	de Che Limite
	oth with the Marylen 23a or 28a-f show unt be notified at rai Director									ide City Limits
	vith the Mar or 28a-f s be notified	MD Baltir	nore	Catonsv	1111e			10g. Citizen of V		Δ.
	h with		Rđ.		212	28		USA	1	
	effer deeth v or Nama 23 unfret munt	11. Meritel Stetus	12. Wes Decedent Ever in U Armed Forcas?	J,S. 13. Wes	Decedent of h	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Raci Blac	e - American India	an,
	020 urs efte arr, or ft		If Yes, Giva		Yes 2/1 No	Specify:	- Handard Control	Specify		P
			Year or Dates:	16a. Decedent	's Usual Occup	pation		16b. Kind of Bu	usiness/Industry	_
	21215-0 ed within 72 ho ygiene. er than 'natur it, the Medeal	(Specify only highest gi	rade completed) Collega (1-4or 5+)	(Give kind	d of work done NOT use retire	during most of work	ing		,	
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	Maryland 212 42 should be filed with the end Mental Hygiene. 7 is marked other than traumatic event, the To Be Comi					18. Mother's Nam Audrey			10)	
	should and Men market umatic	Truman Beaver:		19b. Mailing A	Address (Street	and Number or Rur			State, Zip Code)	
	≥ p±2±	Patricia Beav				Rd. Cat				
	0 0 0 - 2	20a. Mathod of Disposition  1 Burial 2 Cremation 3 ( 4 Donation 5 Othar (Spec	□Ramoval from Stata C	Place of Disposition compteny, cremate edar Hi	on (Name of pry or other ple 11 Ce	metery	Date . 1/16/	20c. Location - 99 Broo	City or Town, Sta	ark, M
	Baltim permit. Peg Department important: It any injury o	21. Signatura of Funaral Sarvica Lica	arkel			ass of Facility - Ashton-				
		23a. Pert1. Entar tha disaasa, or cor shock, or haart failure. List ont	nplications that caused the daat y ona cause on aech lina.						Approx	ximata al Between
	Physician /Medical Examiner	Immediata Causa (Final disaase or condition resulting in deeth)	Sep	ois					Two	and Death  weeks
		No. 11 to 10 to 1	Chrone	or as a consequer	nce of):	Foilus	,		3 m	onthis
6	8760, ate be executed thysician and the buriel-trensit		b	or as a consequer	rice of):	Failur	L'seas	1	5	years.
- 13	P.O. BOX 68760, not the death certificate be executed by the attending physician and letached for use as the buriel-trensi Physician/Medical Exami	that initieted events resulting in death) Last	o. Per for	or as a consequent					20	days
31	death	Part II. Other elamiticant conditions	Total city time to death but not see	white is the unde	duing seven si	on in Bost I	22h Did	tohonoo umo oo	ntribute to the ca	une of death?
C.	by the darched	Part II. Other significant conditions	Huan row	sulting in that unde	mying causa gr	ven in Parti.		Yes 2 No	3 Probably	
8	by be by	01	1	α.					,	
4	aw requir	Corona	ry Artery	Ane	ase		24a. Was	an autopsy omed?	24b. Were auto available p completio of death?	opsy findings prior to in of cause
	: The i						10	Yes 22 No	1 ☐ Yes	2 No
7	ysician: The secreticate director, pag	25. Was case referred to medicat axaminar?	Hospital:		Ott	26. Place of Deal			- 40 - 40	
	0 5 5 5	27. Mannar of Daath	28a. Data of Injury (Month, Day Year)	28b. Time of	3 DOA 28c. Inju	4 □ Nursing Ho		dence 6 D0th how injury occur		
8.	ISION O ttending Ph death. ctor: After th y the funeral	1 Natural 5 Panding investigation	on	Injury		Yes 2 No				
*	DIVISION all or Attending s after death. It Director: Attended in by the fune Certification	3 Suicide 6 Could not 4 Homicide detarmined	28a. Plece of Injury - At h building, etc. (Specif	oma, farm, street,	, factory, office		281. Location ( City or To	Street and Numb wn, State)	per or Rural Route	Number,
NAME	DIVISION Control to the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Cartifiar (Check only one) Certifying P	hysician: To the best of my knominer: On the basis of examine and manner stated.	owledge, death oc etion end/or invest	curred et the ti	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner es stated. and due to the ca	use(s)
Z	To the within 2 To the comple	29b. Signature end title of contifiar	M.D.		29c. Licens	se number			Month, Day, Ye	
	(V	30. Nema end addrass of person who	orton Ave	e Ba	Ptimo	ore, MI	2122	9 To	dd c.R	jau
R	State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signe	- // // //	Spor	K				



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Byard Joseph 0707 1999 Nevember 10 /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 1☑M 2□F 48 Yrs. 213-54-3196 Director 19 1951 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Herns 23s or 28s-f show the Medical Examiner must be notified at 1 Q yes 2 □ No Md Directo Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Ventnor Terrace 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Merital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Gift Shop permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Itam 27 is marked other any injury or other traumatic event, It 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 William Byard Ruth Noves 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Byard/wife 115 Ventnor Terrace, Balto, Md. 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1⊠ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn 11/13 Baltimore, Md. 21. Signature of Funeral Service Link 22. Name end Address of Facility Bradley Ashton Matthews Funeral Home Inc 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode to dying, such as caldiat or respiratory affect.

Balto, Approximate 1222 Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 12 hours disease or condition resulting in death) Cardiogenia Examiner Due to (or es a consequence of): Examine Myscardia 12 hours attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Caronary Atheroscleres, s Box 68760, 10 years Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Pulmonary edema Records. P 24b. Were eutopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed After this certificate has 1 Yes 2 WNo 1 Yes 2 No Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred edical Certification: if or Attending P after death. | Director: After t 5 Pending investigation 1 Netural Injury 1 Yes 2 No 2 Accident t e 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hoepital of within 24 hours af To the Funeral D completely filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certified 29c. License number MD RES-000 10, 1999 November 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95** 

State

**ORIGINAL** 

Street

32. Registrer's Signeture

Geneva

Wolfe

NOV 171999

600 North 31. Date filed (Month, Day, Year) Tour 110 Baltimore Maryland

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21205

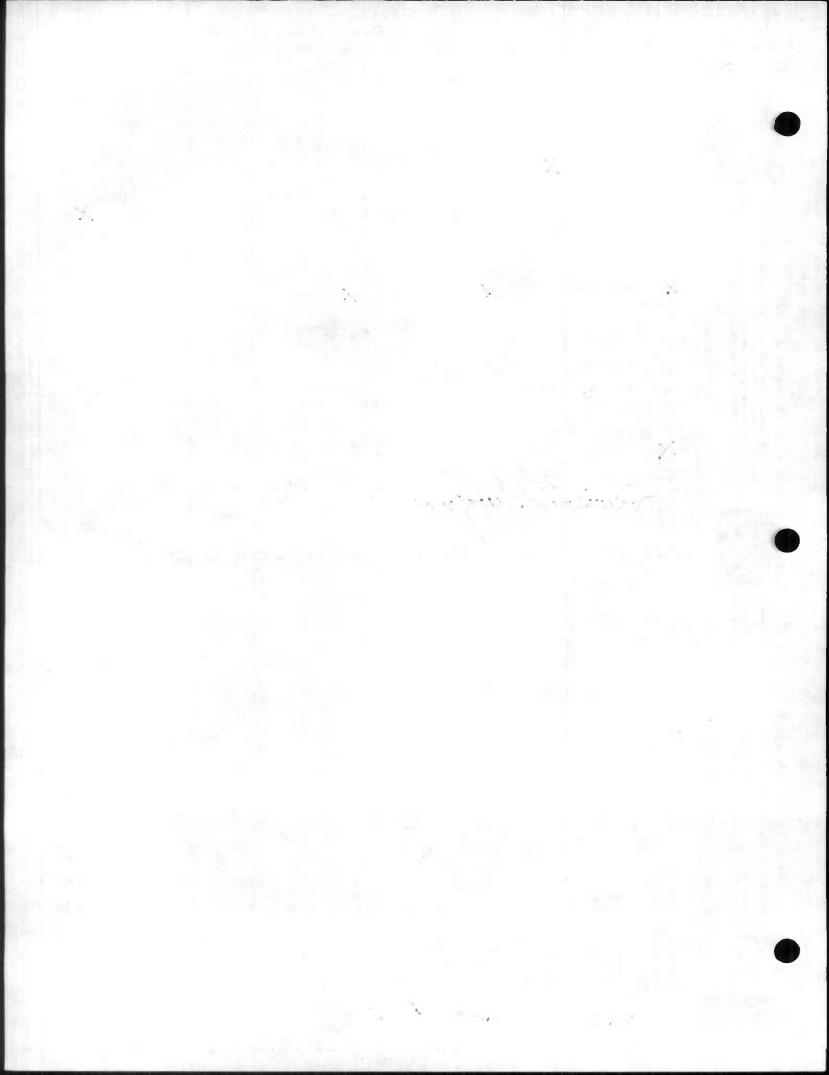
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State of Maryland / Department of Health and Mental Hygiene 99 36031

GEO	RGE CAR	ΓEF	R JR.		y	Cert	ificate of	Death		Reg. N	o.	) (	0001
			1. Decedent's Nama (First, Middle,	Last)					2. Data of D	Death		Vons	3. Tima of Death
	Physicia /Medic		GEORGE ISAG	CARTER	, JE	R.			NOVE	1BER	13,	1999	1521 PM
	Examin	_	4a Facility Nama (If not institution,	give street and number;					or Location of Dea	ath 4	c. County		
	·		SINAI HOSPITAL						RE CITY		N/	A	
	Funeral Director		5. Social Security Number	3. Sex 7. Ag	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Yaar Months Days			Day, Year		Coun	lace (State or Foreign try) YLAND
			214 98 7343 Usual Residence of Decedent		1/	1				) 12	01	TIAN	LUAND
	ahow		10s. Stata 10b. County		10c. City	, Town or Loc	ation					1	Od. Inside City Limits
	Ma -	ig	MD. N/A		BAI	LTIMOR	RE						12 Yas 2□ No
	5 28 E	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of V	Vhat Coun	try?
	deeth with the Maryland rms 23s or 28s-1 show r man be notified at	100	3929 BELLE A	VENUE			2121		U.S. OF A.				
늘 프림		by Funeral	11. Marital Status  12 Never Married . 2 Marrie  3 Widowed 4 Divorced	Armed Forces	1 Yes 2 No If Yes, Give			Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F				e - Amaric k, Whita,	
8	natural,	2		Year or Dates:		16a Doordo	ent's Usual Occu	nation		16b I	Kind of Bu	isiness/Inc	
215-0020		Completed	15. Decedent's (Specify only highest	grade completed)		(Give k	ind of work done  O NOT use retire	during most of v	vorking	100.1	KING OF DU	1511105571110	Justry
212	within than	E	Elementary/Secondary (0-12) UNKNOWN	College (1-4or	5+)	STUDE				PIIR	LTC	SCH	001.
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Σ	and 2 eith 27 I		GEORGE I. CAR	TER, SR. (F.	ATHE	R) 392	29 BELL	E AVEN	UE BAI	LTIM	ORE,	, MD.	21215
J.	of He T		20a. Mathod of Disposition		20b. Pl	of Diames	ition (Nama of atory or other pla		Date	20c. l	ocation -	City or To	wn, Stata
E	Page nent on ry or		1 Burial 2 Cremation 4 Donation 5 Other (Sp.	B □Removal from Stata acity)	VO	SHELL	MEMORI	ALGAR	BENS	BAL	TIMO	ORE,	MARYLAN
altimore	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hyglene. Important: if Ifem 27 Is marked other than ery Injury or other traumatic event, the Mana.		21. Signature of Eefresal Service L	WYS 7.	GWY	NN 22.	Nama and Addr	ess of Facility				010	15 (202
0	Dep de la		1 Lewis	11/11	1/1								15-6393 .,MD.
			23a. Part1. Entar the disease, or o	omplications that cause	d we death	. Do not enta	the mode of dy	ing, such as card	HTS AV	arrast,	<u> </u>	ALIO	Approximata Intarval Between
	Physician /Medical	Н	Immediata Cause (Final disease or condition Bunt Ponts Dhunt with Court on one										
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	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions.	b	Due to (or	as a consequ	ence of):						
0	lan a	Ä	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events									i	
68760,	hysic the b	edicai	that initiated events resulting in death) Last	С	Due to (or	as a consequ	ence of):					1	
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Box	death cert e attendin od for use	a Z		d								1	
	the aft	Physician/N	Part II. Other significant condition	contributing to death t	out not resu	ilting in the un	derlying causa gi	iven in Part I.	23b. Di	d tobacc	o use cor	ntribute to	the cause of death?
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S	2 5.2	٥		···								1 au ur	C. No.
Records,	been s	Completed								as an autoriormed?	opsy	ava	are autopsy findings ailable prior to mpletion of cause
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Division	or At after of Direct in by	Certification:	4 Homicide detarmin	ed 289. Place of in building, el	c. (Specify	)	et, factory, office	13-	City or 1	own, Sta	ta)		Il Routa Number,
	Dital		00s Cadifica		THEE				- 10	-			. N secución
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai		Physician: To the best taminer: On the basis of	f axaminati								
	To the Within 2 To the comple	Ž	29b. Signature and title of certifier	and manner st	ateo.		29c. Licen	se number		29d D	ata signe	d (Month	Day, Year)
	F 3 F 8		Name of Control	A a Colland	1 1	Un	OCI					14,	
	1 -		moune	no sin	4					LVCVE	/اناب	1-1,	1000
			30. Nama and address of person w	no completed cause of o	death (Item	23a) (Type, P	rint)						

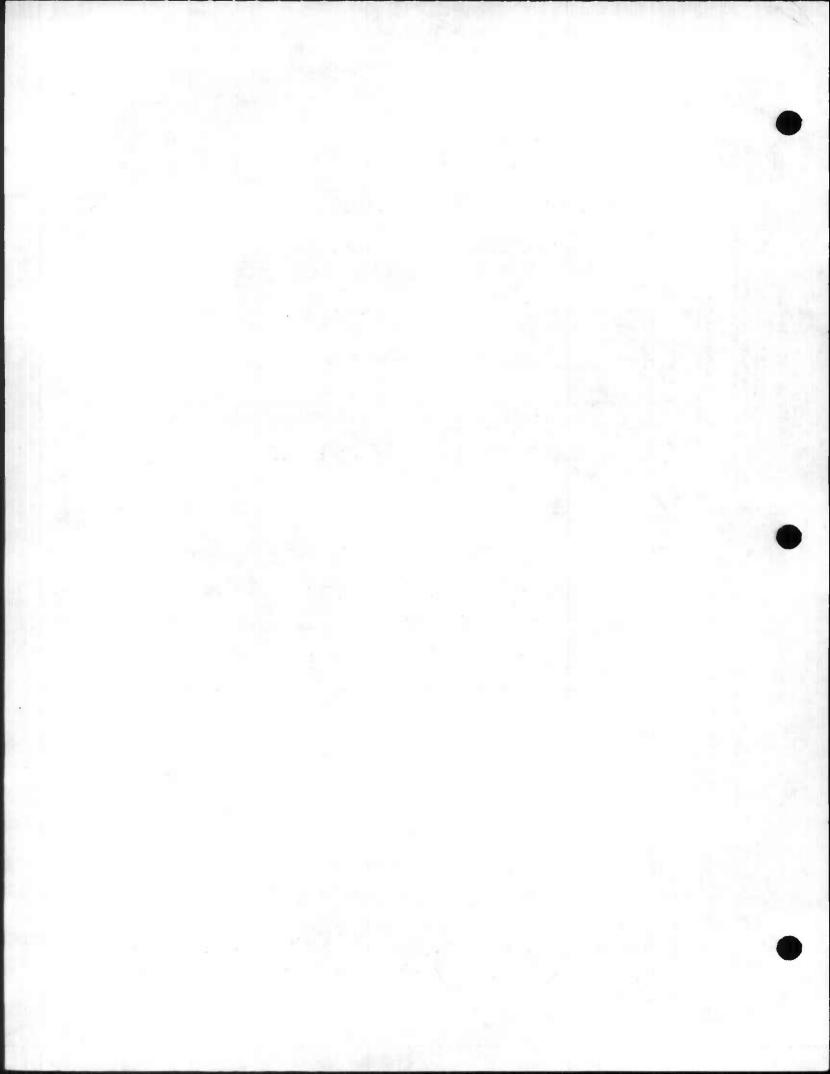
State Registrar

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12 7PM ROSE NOV. 1999 CASSELL /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner POMONA WEST APT. PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 79 Yrs. 8. Date of Birth (Month, Day, 11 24 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 16-1341 1□M 2CH Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If them 27 is marked other than "refund!" or items 23s or 23s-f ahow any injury or other traumatic event, the Medical Espaning man be notified as 10c. City, Town or Location PIKESVILLE 10a State 10d. Inside City Limits 10b. County BALTIMORE XIXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? POMONA WEST APT. 21208 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2XX No Specify Specify: WHITE g 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK STATE OF MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 MORRIS EVNITZ DORA BARTZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JERRY EVNITZ/NEPHEW 10 ESTATES COURT #5205 BALTO. MD. 21208 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, cremetory of other place) AMUNO 1 LINGTON CONGREGATION 11/15 1 Buriat 2 ☐ Cremetion 3 ☐ Removel from State ARLINGTON 4 ☐ Donation 5 ☐ Other (Specify) 99 BALTO. 22. Name end Address of Fecility SOL LEVINSON & BROS. INC. 21. Signeture of Femeral Service Licenses 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician end for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last P.O. Box 68760. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. pege 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital 8 25. Was case referred to medical examiner? 26. Place of Daeth (Check only one) Other: 4☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Neturat 1 Yes 2 No a 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier within 2 To the 29b. Signeture and little of certifier 29d. Date signed (Month, Day, Year) 0 Moh 31. Dale filed (Month, Day, Year) 32. Registrar Signature State Registrar



Amend .	tem#19a perHF G777 11/1	7/99 EW	Ce	runcate o	Dealli		Reg. No.			
Physician /Medical	Decedant's Nama (First, Middla, Last LOUIS	<i>t</i> )	C	APLAN		2. Data of De Month		3. Tima of Death 1999 8:00 A.M.		
Examiner	4a Facility Nama (If not institution, give VAMHCS, FORT HOWA	*			4b. City, Town, o	VARD	BALTIN			
Funeral Director	211-03-3980		yrs. last birthday, 93 Yrs.	Months Day		n. 8. Data of Bir (Month, Da JUNE 4	T 1906	Birthplaca (Stete or Foreign Country)     RUSSIA		
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No N	MD BALTIMO	KE K	ם אם מכס.	_						
death with the Maryland ms 23s or 28s-f show mant be notified at	10e. Street and Number 2214 HAMILTOWNE	CIRCLE	10f. Zip Code 21237		10g. Citizen of What Country? USA					
P 2 2 3		12. Was Decedent Evar Armed Forces? **CLYas 2 \_ No W fryes, Giva Yaar or Datas;	W III	Was Decedent of If Yas, specify Cu 1 ☐ Yes XXN		(Specify Yas or No erto Rican, atc.)	14. Race - American Indian, Black, White, etc.  Specify:WHITE			
Maryland 21215-0020 d 2 should be filed within 72 hours af the and Mental Hygiene. 7 is marked other then "natural; or traumatic event, the Mexical Example To Be Completed by 8	15. Decedent's Ed (Specify only highast gra	ucation da completed)	16a. Deca	dent's Usual Occ kind of work don DO NOT use reti	e during most of w	rorking	16b. Kind of Bu	siness/Industry		
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ld be fill the contain the con	CAMITE		CAPL	AN	IDA			IRKIS		
T merk	19a. Informant's Name/Reletionship (	vne Print)				Rural Routa Numb				
Ma d 2 s d 2 s d 2 s T is r	Wayne HENRY CAPLAN/NE	** **					in Car Carlo			
Heal ther	HENRY CAPLAN/NE 20a. Mathod of Disposition	PHEW	5380 The Place of Disp	IRVING	RUBY RI			D. 21784 City or Town, Stata		
Baltimore, semit. Pages 1 er separtment of Hea mportant: If Item iny Injury or other noce.	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Stata	cematery, cre	STATE	POST167	11/14/		LE, MD.		
/Medical /Medical Examiner	Immediate Causa (Final disaasa or condition resulting in deeth)	a. COLON CAN	NCER					Onset end Deeth		
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oenflicate be assecuted dring physician end ise as the burial-trensit	Sequentially list conditions, if any, laading to immediate cause. Enter Undertying Causa (Disease or Injury that initiated evants resulting in death) Last	C	to (or as a conse							
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P.O. hat the de by the detached detached	Part II. Other significant conditions or	entributing to death but not	t rasulting in tha u	inderlying causa	given in Part I.		tobacco use con Yes 2 No	atribute to the cause of death		
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Vital Rec						1 🗆	Yas 2 No	1 ☐ Yas 2 ☐ No		
/ita	25. Wes casa raterred to medical				26. Place of D	eeth (Check only	one)			
of Vita Physician: this certific tral director,	axaminar? 1 ☐ Yas 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Homa 5□ Rasi	dence 6 Othe	ar (Specity)		
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Division of Vital Re- To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.		reet, factory, offic	÷0	28f. Location ( City or To	Street and Number wn, Stata)	er or Rural Routa Number,		
Ne Hospitu n 24 houns ne Funera pletely fille		rsician: To the best of my iner: On the basis of axan and mannar stated.								
To the comp	29b. Signatura and titla of certifiar	,		29c. Lice	nse number		29d. Data signed	(Month, Day, Year)		

ow injury occurred treet and Number or Rural Routa Number, n, Stata) ause(s) and mannar es stated. ata and place, and dua to tha cause(s) 29d. Data signed (Month, Day, Year) FORT HOWARD, MARYLAND 21052

State Registrar

31. Dete filed (Month, Day, Year)

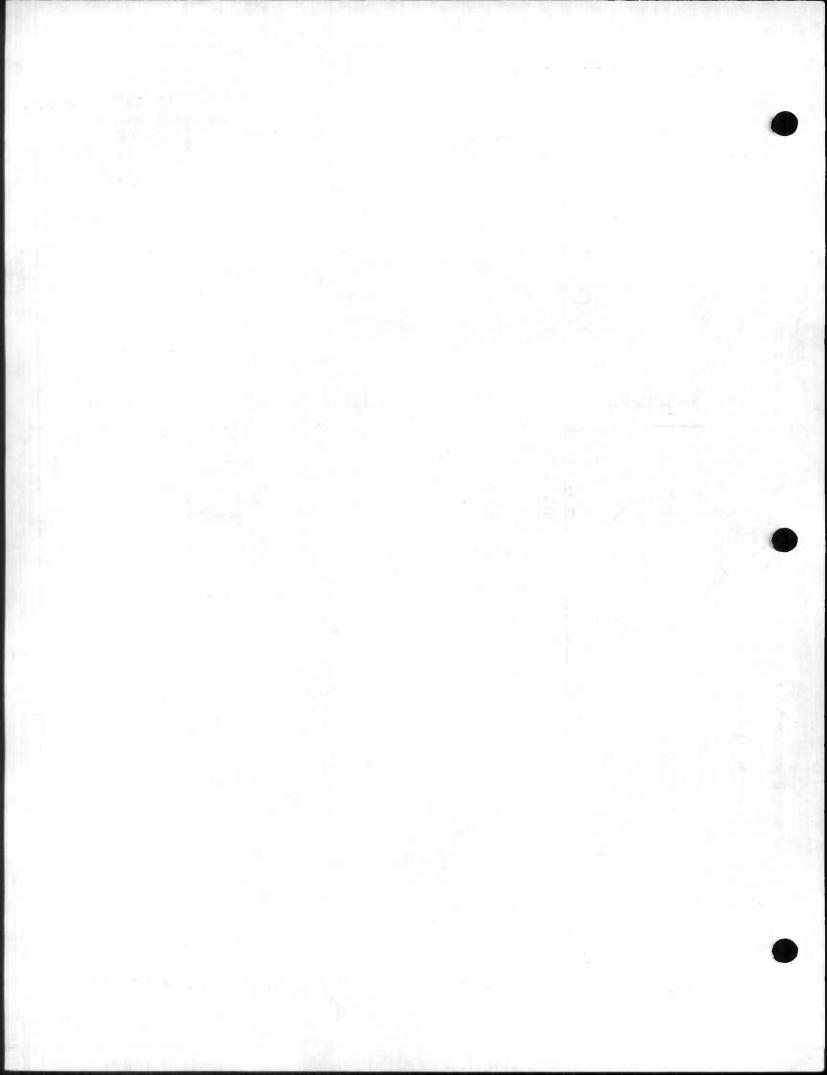
DR. SURESH SHANDELYA,

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

511

M.D., 9600 NORTH POINT

32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 36034 Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Barbara Rhona Crowther 99 10:05 PM NOVEMBEN 5 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Union Memorial Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1□M RXF Yrs Director 219-26-7227 61 Feb. 18,1938 | Maryland Usual Residence of Decedent with the Meryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at Yes 2□No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3832 Elm Avenue 21211 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Bleck, White, etc. 2 should be filed within 72 hours effer ond Mentel Hygiene. is marked other than "natural", or ite 1 ☐ Yes ♀ No If Yes, Give Year or Dates: 1 ☐ Never Married X Married altimore, Maryland 21215-0020 1 Yes X No Specify: Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Keener Benjamin Albaugh Mary Emma Jenkins 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health e Important if item 27 is Rolan G. Crowther Husband 3832 Elm Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 Cremetion 3 Removal from State ò Crest Lawn Memorial Grdn 11/19/99 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility any it Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 are the disense of complication. Met caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and an analysis. List only one caused on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical STEATOHEPATITIS 2 MONTHS Examiner Due to (or as a consequence of): Examiner I MONTH PRELLMONIA physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequence of): certificate be execu P.O. Box 68760. Physician/Medical Due to (or as a consequenca of) 98 use ( 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown p Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed pege 2 s certificate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28h. Time of Certification: or Attending 1 Natural 2 Accident 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No efter deeth Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours e Hospital Certifying Phyafcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOV 15, 1999 MD AT-2438946 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 201 E. UNIVERSITY PKWY BALTIMORE, MD 21218 UNION MEMORIAL HOSP. MANGLA GULATI

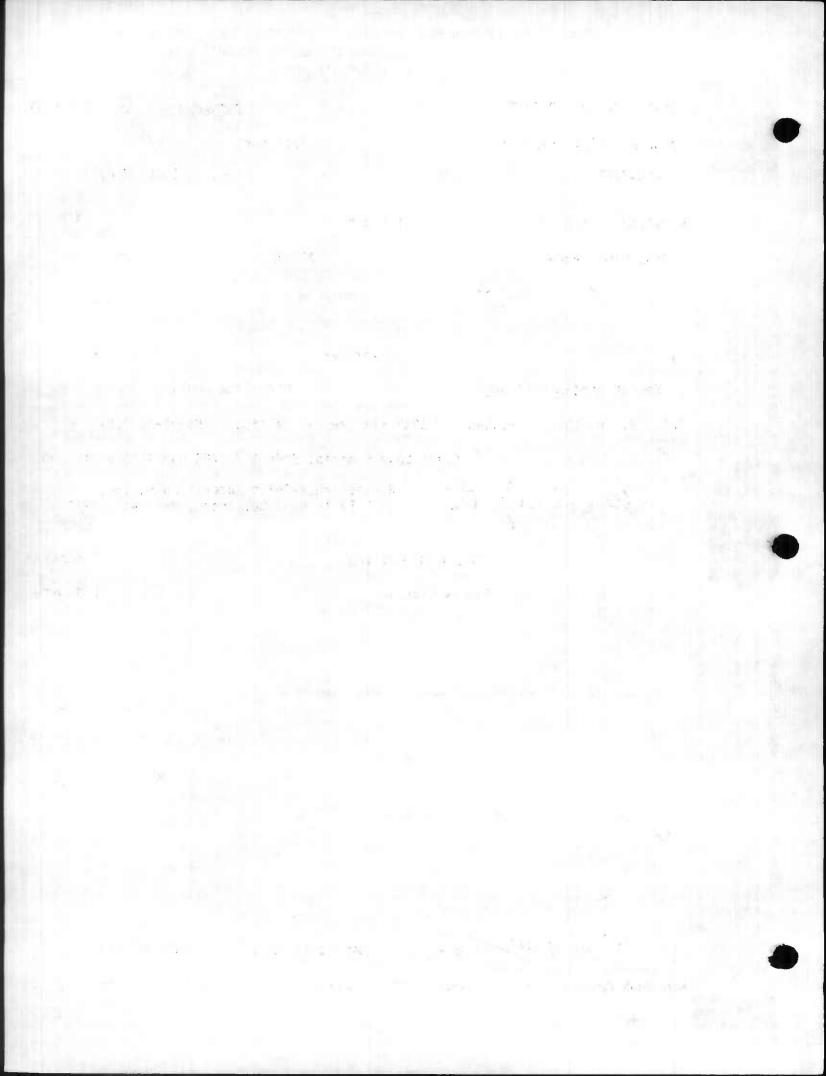
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Registrar NOV 1 7 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signature

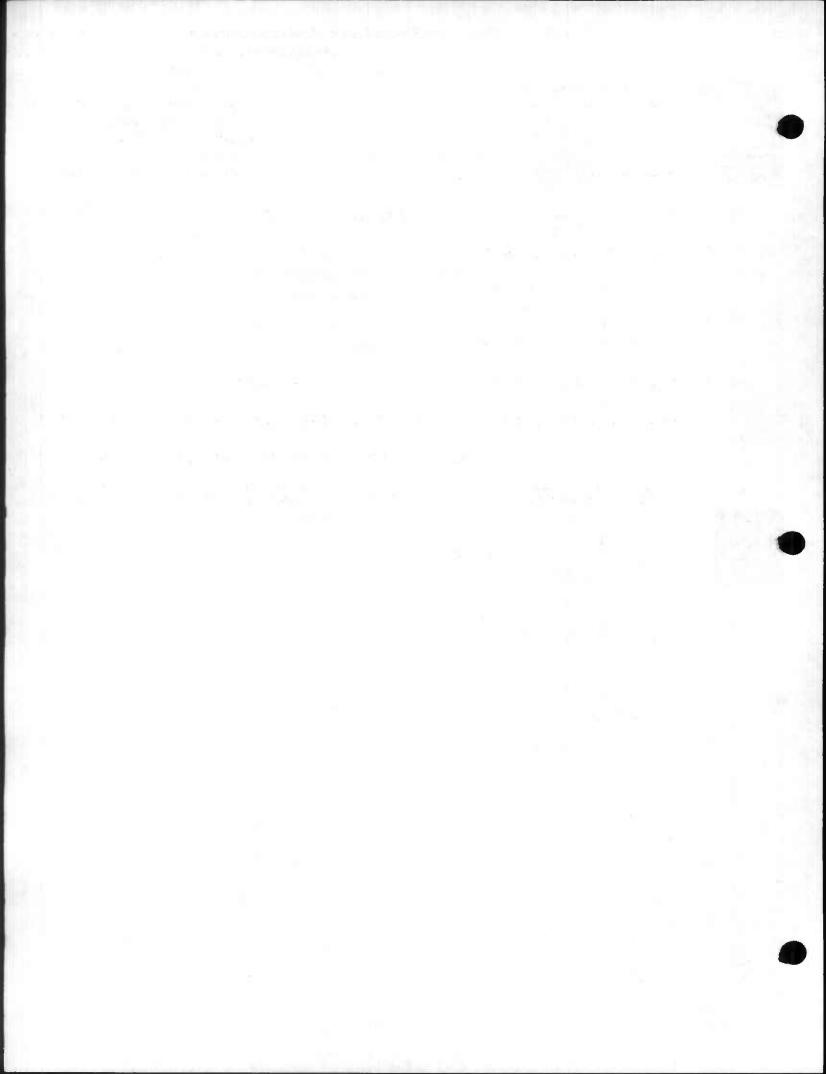
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State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	f Death		Re	g. No.			
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	Funeral Director		5. Social Security Number 6. Se 220-12-4884	x 7. Age	e (In yrs. lest bi	Yrs.	If Under 1 Yea Months Deys		24 Hrs. Min.	8. Date of Birth (Month, Dey, 04-10-	of Birth 9. Birthpleca (Stete or Country) -10-1910 MARYLAND			
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	23a or 26	Funeral Director	10e. Street end Number 700 WEST 40t	h. STRE	ET		10f. Zip Code	21211		10	og. Citizen of \	Whet Count	try?	
5-0020	or its	b	11. Marital Status  1 □ Never Married 2 □ Married  X3 Û Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 Tyes X2X N If Yes, Give Year or Dates:		- If	Vas Decedent of Yes, specify Cu	ban, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)		e - America ck, White, c		
21215-0	36	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12) 12 YEARS	le completed)	16a. Decedent's Usuel Occupati (Give kind of work done du life. DO NOT use refired) TEACHER			e during mos ed)	st of workin	ng	EDUC			
Maryland 2	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if herr 27 is marked other than any Injury or other treumatic event, tra Menue.	17. Fether's Neme (First, Middle, Last) AQUILLA BROWN HANSON E						er's Neme	(First, Middle, M	faiden Sumen LLIAM	,			
	1 end 2 should Heelth end Men em 27 ls merke		19e. Informent's Neme/Relationship (7) SANDRA H. HARGRA			,				Route Number,			Code) D,21204	
Baltimore,	. Peges 1 ment of He lant: If Iten lury or oth		20e. Method of Disposition 1 ☐ Buriel X2X☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemete	ery, crem	etion (Neme of etory or other pi OUNT CI	ece) REMAT	ORY		BALTO		wn, Stete	
Bal	21. Signeture of Funerel Service Licansee  22. Neme end Address of Feci HENRY W. 4905 YORK RO						Y W.	ĴENK	INS AN	D SON RE,MA	S CO	MPANY ND,21212		
	Physician /Medical Examiner	J.	23a. Pert1. Enter the diseese, or complishock, or heert failure. List only of Immediate Ceuse (Final disease or condition resulting In deeth)	e. ASC	e.			ring, such es	cardiac o	r respiratory erre	st,		Approximete Intervel Between Onset end Deeth	
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Division		Certification:	27. Manner of Deeth  1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Dete of Injur (Month, Day	Year)	Time of Injury	M 1[	ork? ☐Yes 2☐	No	8d. Describe ho				
1   Neture   2   Accident   3   Suicide   4   Homicide   2   Medical Examiner: On the basis of examinetion end/or investigation, in my of end manner stated.   29c. License   29c. Licen								8f. Location (Str City or Town	, Stete)					
	To the Hospital within 24 hours To the Funeral completely filled	edicai	(Check only one)	ner: On the best of end manner sta	examinetion er	e, aeeth nd/or inve	estigation, in my	opinion, des	th occurre	ng due to the ca d et the time, da	use(s) end me ite end pleca,	end due to	eted. the cause(s)	
	To the com	M	29b. Signeture end title of certifier  Ose grand	one.	מח		29c. Licer	6619		29	od. Date signe	d (Month, I	Dey, Year)	
	1		30. Name and address of person who co	empleted cause of de	eeth (Item 23e) 700 K	(Type, P	oth stre	ret .	Bal	h'more,	no.	2121	/	
	01-	4.0	31. Dete filed (Month, Dev. Year)	32. Registre	r'e Signatura	1								

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death November 11 99 9:30 p.m Lillian Cohen 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Howard County General Hospital If Undar 24 Hrs. 8. Data of Birth 1 2 Month, Day, Year) 6 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthplaca (Stata or Foraign Days Min. Months Hours 1□ M 2□ F England 056-52-1036 Director Usual Rasidence of Decedent 10c. City. Town or Location 10H SWard 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Director Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 USA 5154 Phantom Ct Completed by Funeral 12. Was Decedenf Evar in U,S. Armed Forcas? 1 ☐ Yas 之 No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify. Specify: White 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 17. Fafhar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Hilda Unknown Solomon Borsook 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)
82 Susan Dr. Newburgh NY 12550 19a. Informant's Name/Ralationship (Type, Print) Adele Grossman/ Daughter 20a. Marhod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☑ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 11/14 Flushing, NY Mt. Hebron 21. Signatura of Funaral Sarvice Licensee 32 Per in My ss A Still on Schwab Funeral Home Inc Marila 736 Edmondson Avenue Balto. MD 21228 23a. Part1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat end Death Immediata Causa (Final disease or condition rasulting in death) /Medical Physician/Medical Examine monon ye ars Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown none Completed by 24b. Were eutopsy findings availabla prior to complation of causa of death? 24a. Was an eutopsy performed? 1 ☐ Yas 2 No 1 Yas 2 No Be 25. Was case refarred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Neturel 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, and dua to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stafed. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nama and addrass of person with completed cause of death (Item 23a) (Type, Print)

Crown Li Evens ley MD 4801 Darsey Hell Drive Ellicitt City

State Registrar **DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) 32. Registrar's Signatura

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Examinar mast be notified.

Examiner

g physicien and as the burial-transit

USB

ata has been signed by the a page 2 should be detached

**Physician** 

Box 68760. P.0. Division of Vital Records,

The law requires that the deeth certificate be assecuted

or Attending Physician:

To the Hospital

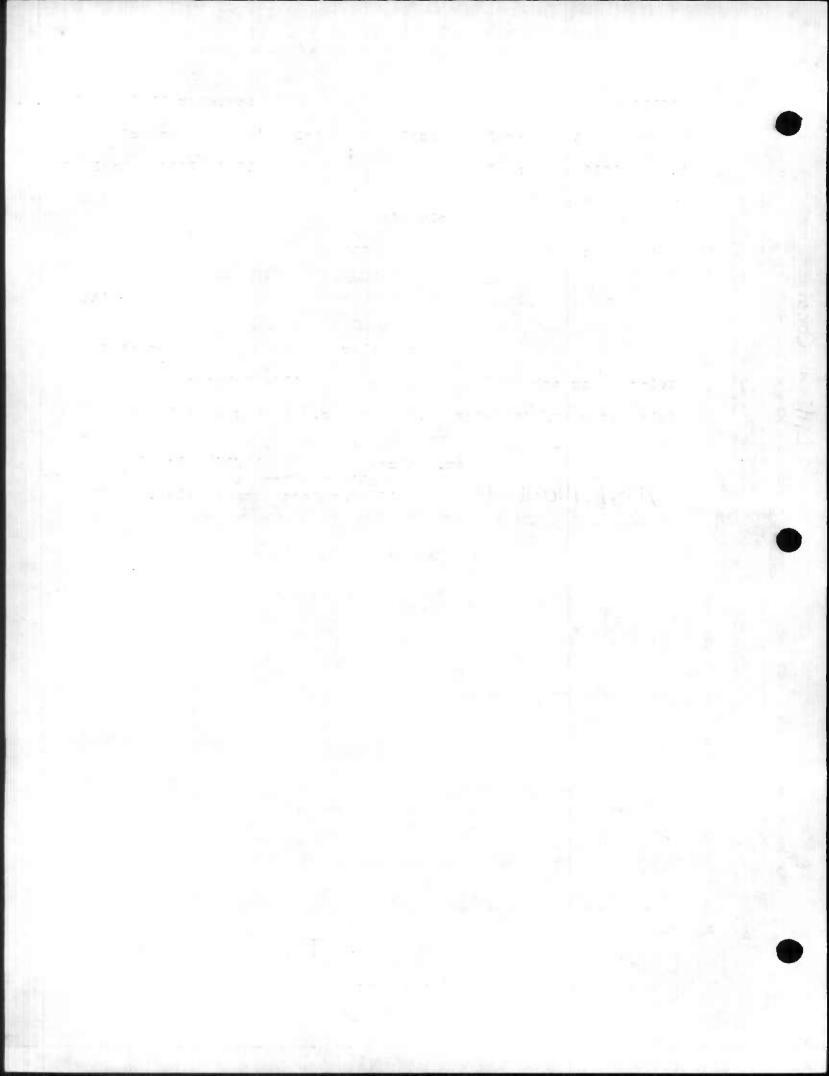
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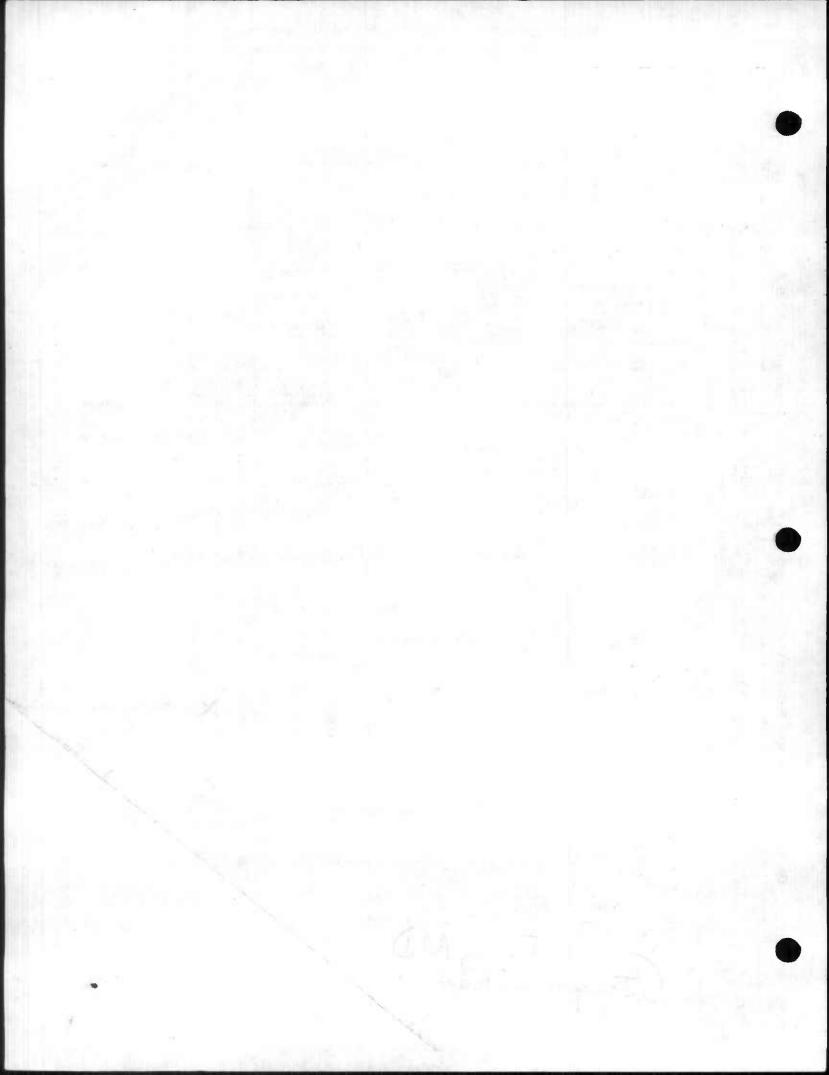
within 24 hours after deeth. To the Funeral Director: A



# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

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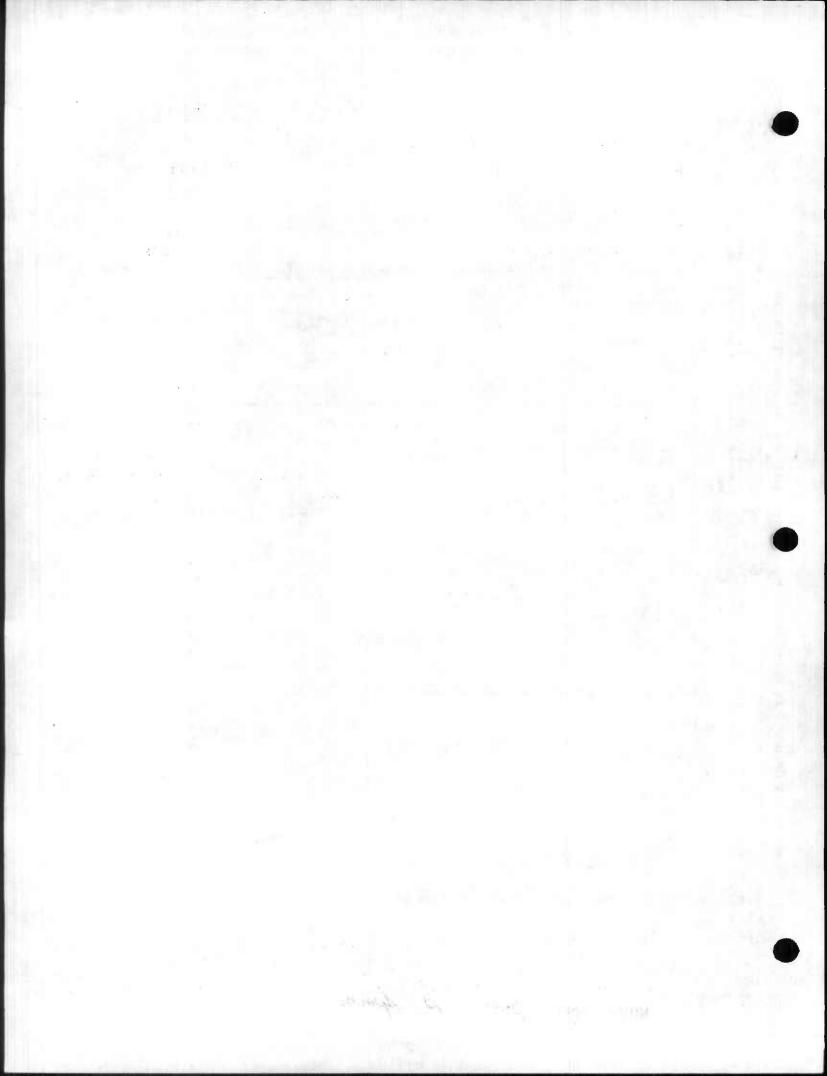
	ER FH G778 12/27/99 AH			Certificate o	t Death	F	Reg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, La Norman Carmo	st)				2. Date of Dea Month NOVEM	Day	1999	3. Time of Death 8:39 P
Examiner	4a Facility Name (If not institution, giv NORTHWEST HOSPI				4b. City, Town, o	or Location of Death STOWN	,	of Death	
Funeral Director	1,5 3. 5100	Sex 7. Age 58	(In yrs. last birtho Yn	Months   Day			1941	9. Birthpla Countr West	ca (State or Foreign y) VA
Varyland f ahow	Usual Residence of Decedent	2.2	10c. City, Town o	rLocation rsville		(10)		100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the Mar 3a or 28a-f at 1 be notified	10e. Street and Number 336 First Aver	,	Dia	101. Zip Code 1571			10g. Citizen of US		y?
semit. Pages I and 2 should be filled within 72 hours effer death with the Maryland Department of Heelth and Meniel Hyglena.  mportant: if item 27 is marked other than "naturel", or items 23s or 28s-I show ny injury or other treumstic event, the Medical Examiner must be notified at MAGE.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give X Year or Dates:	Ever in U,S.	13. Was Decedent of the Yes, specify Control of the Yes 200 N	(Specify Yes or No- erto Rican, etc.)	Specify Yes or No- lo Rican, etc.) 14. Race Black Specify:		ce - American Indian, ack, White, etc. by: White	
ygiene. Ner then "neture It, the Medical Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(0	ecedent's Usual Occ Give kind of work dor de. DO NOT use reti Painter	cupation ne during most of w red)	of working  16b. Kind of Business/Industry  Machine Manufactu			
Mentel Hyg arked other atic event, To Be C	17. Father's Name (First, Middle, Last) Walter Carmo,					ame (First, Middle, Spangle)		10)	
selth end h	19a. Informant's Name/Relationship ( Linda Carmo/Wi		196. A 3 3 6	Mailing Address (Stre First A	ve. Bla	Rural Route Numbe irsville	or, City or Town, PA	State Zip G I 5 7 I 7	Çode)
Department of Heelth e Important: if fem 27 la eny Injury or other tret ance.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Date 20c Location - City or Town, State Blairs Ville, PA							
Departing Inports and Injury I	21. Signature of Funeral Service Licer	who.U		22. Name and Ado Sterling 736 Edmo	ress of Eacility - Ashton ndson A	-Schwab	Funer	al Ho	ome Inc.
Attanding Physician: The law requires that the death certificate be executed relative.  I death.  Setor: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit by the tuneral director, page 2 should be detached for use as the burial-transit lifeation: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as a con	nsequence of):	ascula	rdiseas	SE		
that the death certificated by the attending plateched for use as the physician/Mec	Part If. Other significant conditions of	ontributing to death bu	t not resulting in t	ne underlying cause	given in Part I.	23b. Did t	200	ntribute to t	the cause of death?
s been signe 2 should be d pleted by						24a. Was	an autopsy med?	avai	e autopsy findings lable prior to pletion of cause eath?
for Attanding Physician: The law requires the fact death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	25. Was case referred to medical				26. Place of D	Death (Check only o	res 2□No	128	Yes 2□ No
tal or Attending Physici rs efter death. el Director: After this cei lad in by the funeral direc Certification: To E	examiner?  1X Yes 2 No  27. Manner of Death  Matural 5 Pending investigation 3 Suicide 6 Could not be determined		y 28b. Tin thick	ne of 28c. In	juryat vork? □Yes 2□No	Home 5 Residence	now injury occur	red	
To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fi Medical Certificati	29a, Certifier 1 ☐ Certifying Ph	ysician: To the best of	f my knowledge, o examination and/o	leath occurred at the or investigation, in my	time, date and pla y opinion, death oc	ce, and due to the	cause(s) and m	anner as sta and due to t	ited. the cause(s)
within 2 To the comple	29b. Signature and title of centiler	tam	, Μ.	29c. Lice O. C	.M.E		29d. Date signe	d (Month, D	Pay, Year)
W	30. Name and address of person who	completed cause of de	eath (Item 23a) (T)		enn Stree	et, Balti	more, M	arylar	nd 21201



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State of Maryland / Department of Health and Mental Hygiene 99 36038

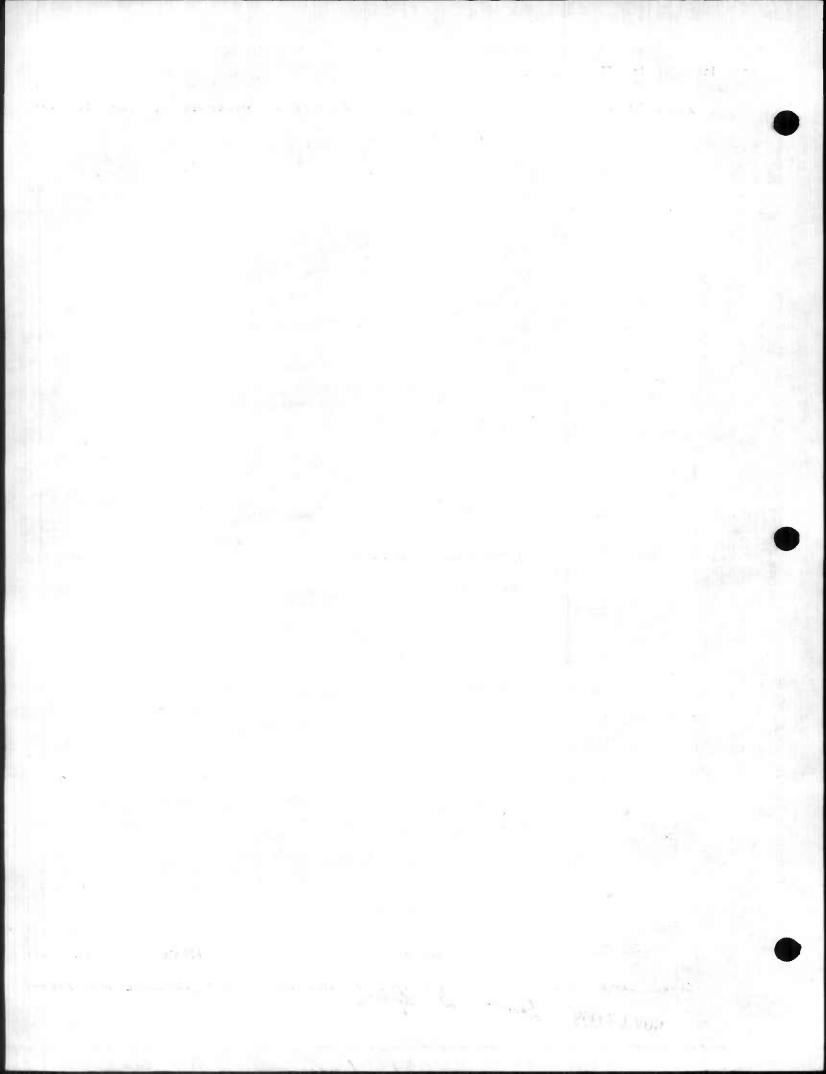
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death	r items 23s	11. Merit	al Status		12. Was Deceder	nt Ever in U	S. 18	3. Was De	cedent of Hi	ispanic Origin? (	Specify Yes or No rto Rican, etc.)			
21215-0020 d within 72 hours after death with the Maryland	, J		Never Married 2		Armed Forces 1 Yes 2 5 If Yes, Give Year or Detes	No No			2½ No	Specify:	no Hican, etc.)	Black, White, etc.  Specify: Black		
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Baltimore,	Important: If I any Injury or DOCS.	21. Sign	1. Signelure of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202  WM.C.March FH 1101 E. North Avenue											nd 21202
<b>m</b> 22	8 5 5 8		Berna	d ps	mount			WM.C	.Mar	ch FH	1101 E.	North	Ave	nue
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To the	Ne Me	29b. Sign	neture and title o	of certifier				T	29c. License		T	29d. Date signed	(Month,	Day, Year)
		•	Sco.	J 2)	t m				280	32		VOVEMZ:	11.	7 1999
-	1	30- <sub>1</sub> Name	and address of	person who	completed cause of	death (Iten	23a) (Îyp	e, Print)	10	112	1	11/-	1	11/1
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	show		10a. Stete 10b. County		10c. City, To	wn or Location					1	Od. Inside City Limits
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	de m	Funeral	11. Maritel Stetus	12. Wes Decedent Ex Armed Forces?	ver in U,S.	13. Was De	cedent of	Hispanic Origin? (S pan, Mexicen, Puer	Specify Yes or No		e - Americ	
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Division	- 9 -	Certification:	4 Homicide determined		y - At home, (Specify)	term, street, tec	lory, office	113		(Street end ivum ewn, State)	oer or Hura	ai Route Number,
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Registrar DHMH 16 Rev 6/95

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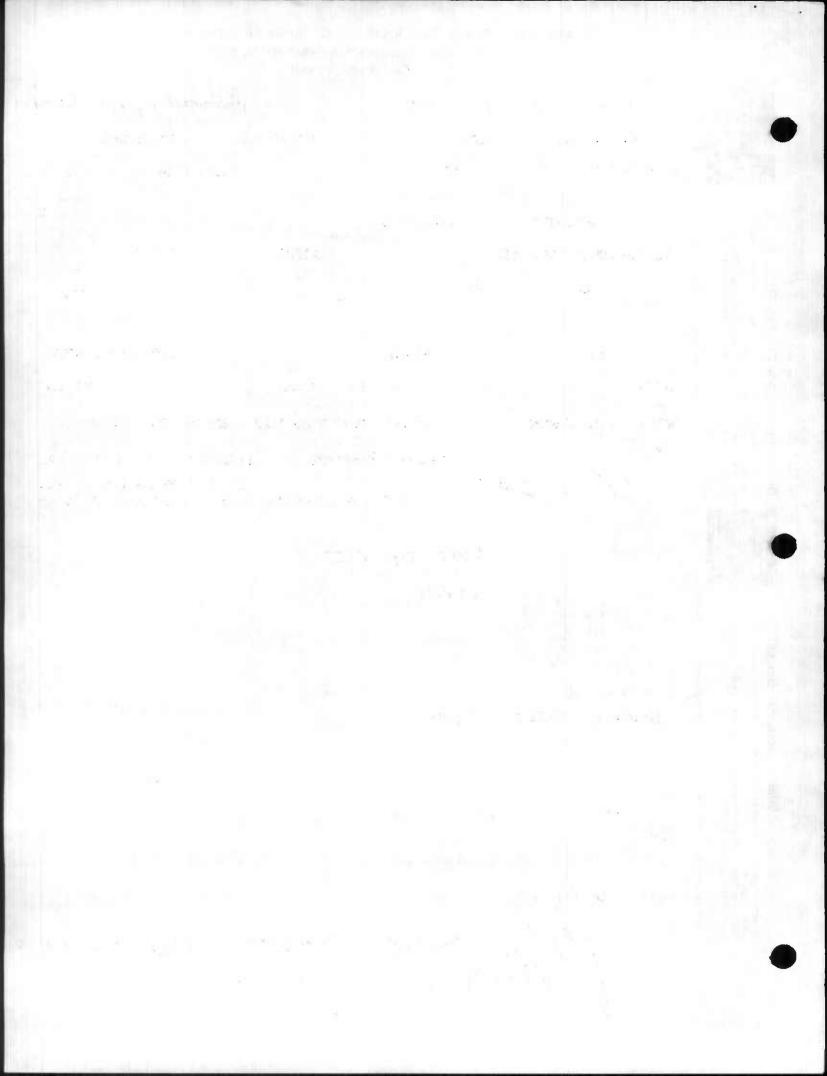
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) NOVEMBERS 11, 1999 **Physician** 6;00PM BERNARD DAVIES /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE H Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) APR . 3, 1916 6. Sax 1 M 2 □ F 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months 218-28-6510 Yrs. 83 **ENGLAND** Director Usuel Residence of Decedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2X No Director BALTIMORE BALTIMORE 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Numbe permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If frem 27 is marked other than "natural", or itema 23a and Injury or other traumatic event, the Medical Exaginer manal state. 16 OLD COURT ROAD #612 21208 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc 1 ☐ Navar Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: WHITE þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) HOME APPLIANCES SALES 18. Mothar's Nama (First, Middle, Maldan Surnama) 17. Fathar's Nama (First, Middla, Last) MICHAEL DAVIES SARAH GOODMAN 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) BETTY DAVIES / WIFE 16 OLD COURT ROAD #612 - BALTIMORE, MD 21208 20b. Plece of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 11/14/99 OWINGS MILLS, MD 21. Signature of unique Service Moerison 22 Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onsat and Death **Physician** /Medical Immediata Causa (Final disaase or condition resulting in death) POST-OP MI Examiner Physician/Medical Examiner JEPS15 ettending physician end for use es the burial-transit The law requiras that the deeth certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760 Dua to (or as a consequance of) 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown been signed by OBSTRUCTION BOWEL þ 24b. Wara autopsy findings available prior to should 24a. Was an autopsy performad? Completed completion of cause of death? hes 1 ☐ Yas 2 ☐ NO 1 ☐ Yas 2 ☐ No cartificate Hospital or Attending Physician: 25. Was casa rafarred to predical axaminar? Be 26. Piece of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Spacify) P 2 ER/Outpatient 3 DOA 1 Yas 2 HO within 24 hours after death. To the Funeral Director: After this funeral 28a. Dete of Injury (Month, Day Yaar) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Tima of Certification: 1 Neturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, fectory, office building, etc. (Specify) 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) completely fillad in by 4 Homicide The contyring Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, end due to the cause(s) end menner as stated.

20 Maryical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of dertifing 29c. Licansa number causa of death (Itam 23a) (Type, Print) 30. Nama and addrass of person who WITERIM Jr. 31. Data filed (Month Day, Year) 32. Redistrar's Signatura State

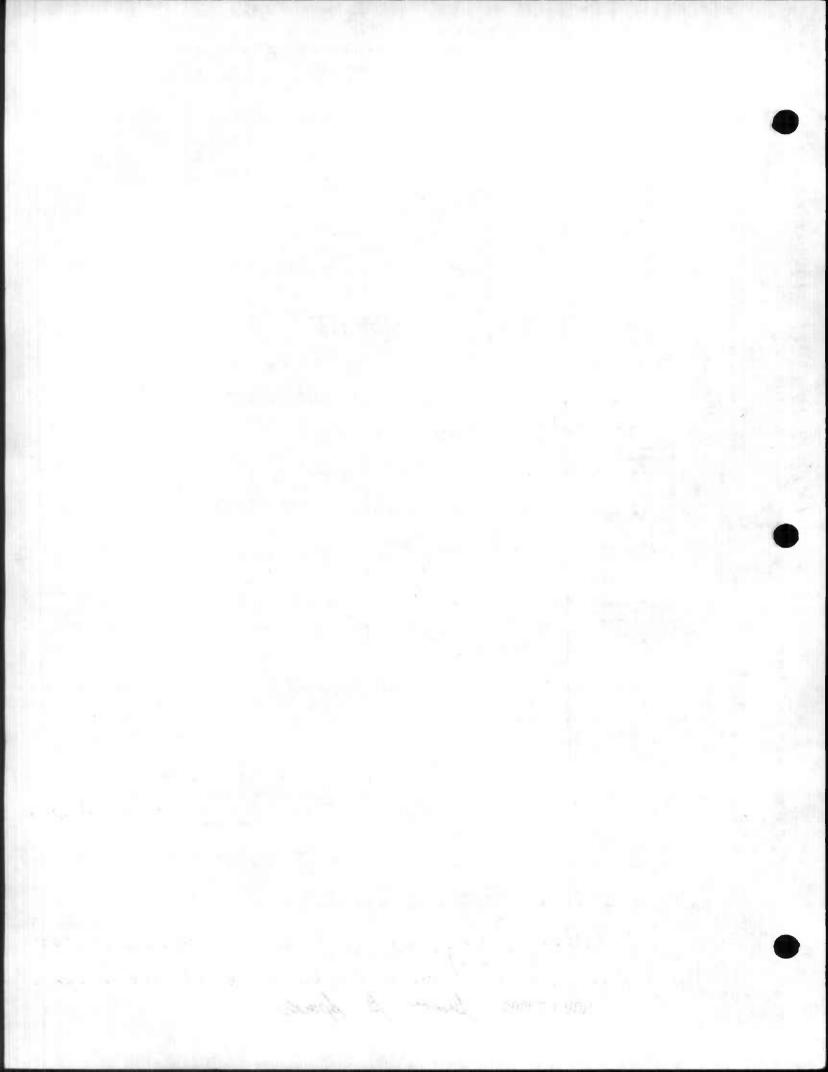
renewa

Registrar

NOV



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Depkin Marry 8:28 pm Henschen November 12,1999 /Medical OVEMBER 121 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Baltimore Gilchrist (enter If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ff Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 10M 20 F 88 212-03-1450 Yrs may 21,1911 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County t 0d. Inside City Limits or 28a-f show 1 ☐ Yes 2 ₽ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä 3336 Willoughby Road 21234 W.S.A. 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rench-Bray Elementary/Secondary (0-12) College (1-4or 5+) Printing Co Foremar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Depkin Edward Hilda Henschen Harry 10 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perryoak Place Baltimore, Marylaz? important: If Item 27 any Injury or other tr Hilda E. Rosenberger-daugh. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of NO1.16. 1 DeBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 1999 22. Name and Address of Facility Evans (Napel of momon es 21. Signature of Funeral Service Licensee 8800 Harford Read teather Ain Baltimore, maniand 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical carcinoma of unknown YEAR Examiner Due to (or as a consequence of) physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown le ment 14 Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No of Vital Attending Physicien: 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending Hospital or Attending n 24 hours after death.
 Funeral Director: After sietely filled in by the lur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier edicai 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and manner stated. 29b. Signature and fitte of portifier, 29c. License number 29d. Date signed (Month, Day, Year) mhm 25205 un 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Bolto and St. Chales 6701 32. Registrar's Monature 31. Date filed (Month, Day, Year) State NOV 17 Registrar

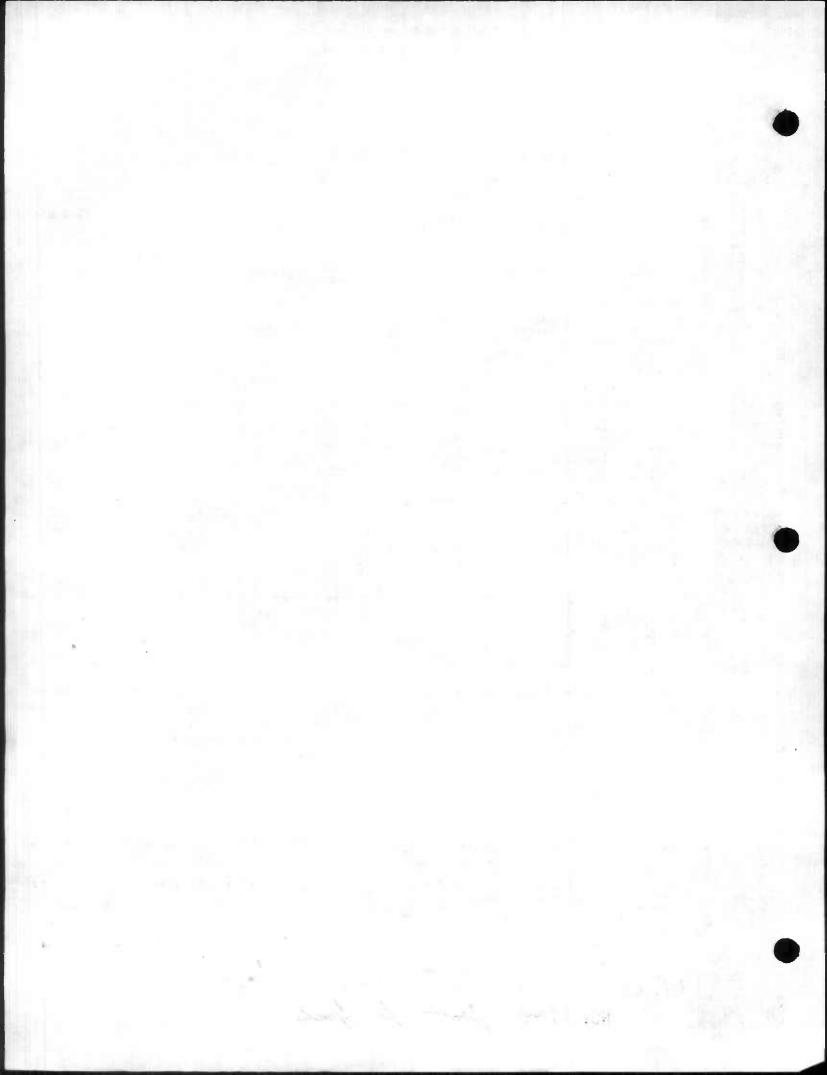


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لاخلا	EN D. I	<i>)</i>	Certificate of Deat			. No.	9 0	10042
			Decedent's Name (First, Middle, Last)	2. D	ete of Death		V	3. Time of Death
	Physic /Medi		HELEN 8. DAVIS		fonth OVEMBE	R 13,	Year 1999	0535 AM
	Exami			y, Town, or Location	of Death	4c. County		
				BINGDON nder 24 Hrs.   8 Da	ate of Birth	HARF		on /State of Fernian
	Funeral Director		212. 34. 2206  1 M 2 F   45 Yrs. Months Deys Hour	urs Min. (A	ata of Birth Month, Dey, Y	(ear)	9. Birthple Country	ce (State or Foreign
	yland Mand		10a. State 10b. County 10c. City, Town or Location				100	d. Inside City Limits
	Meritan transfer	ctor	MO HARFORD EDGEWOOD					1 ☐ Yes 2 ☐ No
	ें इ. १.	Dire	10e. Street and Number 10f. Zip Code		100	. Citizen of W	het Countr	y?
	death with the Meryland ms 23a or 28a-f show r must be notified at	era.	13.00 CLOUER VALLEY  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	o Origin? (Specify)	/os or No		SA	n Indian
	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Depertment of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic avant, the Medical Exercises must be notified and once.	by Funeral Director	Armed Forces?/ If Yes, specify Cuban, Mexic	n, Mexican, Puerto Rican, etc.)  Specify:		14. Race - American Indien, Black, White, etc.  Specify: BLACK		c.
9	2 hou	P	15. Decedent's Education 16a Decedent's Usual Occupation		16b. Kind o			
21	thin 7	Completed	(Specify only highest grade completed) (Give kind of work done during m Elementary/Secondary (0-12) College (1-4or 5+)	most of working				
7	Hygier the	S	12 TH GRADE N/A MTA DRIVER  17. Father's Nema (First, Middle, Last) 18. Mo	fother's Name (Firs	A Adirdolo Ada	TRANS		MON
and	intal H	Be		LEN BOU		iden Sumemi	9)	
Maryland 21215-0020	2 should be end Mantal le marked of eurmatic av	2	19a. Informant's Neme/Reletionship (Type, Print)  19b. Mailing Addrass (Street and Num			City or Town,	Stete, Zip C	Code)
Ž	and 2 paith a n 27 le		JAMES STILLS   SON   2327 AIKEN ST. ,	BALTO.	mo.	21218		
Baltimore,	Pages 1 nant of He int: If Itam iry or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State  4 ☐ Donetion 5 ☐ Other (Specify)  20b. Plece of Disposition (Nama of camelory, cremetory or other place)  EBERNETER BAPTIST CHURCH	Da 11-18		c. Location -		n, State
Balt	pemit. Depertmingortal any inju		21. Signeture of Funeral Service Liounsee  22. Name and Address of Fervice Liounsee  VAUGHN C. GRE	ecility EENE FUN	ERAL S	SERVICE	É	
		Н	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart fallure. List only one cause on each line.			mo. 2		Approximate
1	Physician /Medical Examiner	J.	Immediate Cause (Finel disease or condition resulting in death)  e.   Due to (or as a consequence of):					ntarval Batween Onset and Death
	es that the death certificate be executed igned by the attending physician and be deteched for use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):	1				
m ·	daeth a atte ed for	Sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pe	Pert I.	23b. Did tobi	ecco use con	tribute to t	the cause of death?
0.	et the d by th steche	Physician/M			1 🗆 Yes	2 No	3 Probe	ibly 4 Unknown
Records,	been s	Completed by		2	24a. Wes en performe		evai	e eutopsy findings lable prior to pletion of cause aath?
m m	The lev sta has page 2	mo.			1 Ves	2□ No	13	Yes 2□ No
/Ita		Be	examiner/	Place of Deeth (Che	eck only one)			
5	this or	2		Nursing Home				
nc	Affar	lo lo	27. Manner of Death  1 Naturel 5 Pending (Month, Day Year)  28a. Data of Injury 2  1 Naturel 5 Pending (Month, Day Year)  2 Naccident investigation   1   2 0 0   (1 4 3 ) M  1 □ Yas 2	1/1000		injury occurr	44340	LISION WITH
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartific complately filled in by the funeral director.	Certification:	2 Accident investigation   1   3   9   0   3   A   M   1   Yas 2   3   Suicide   4   Homicide   4   Homicide		ocation (Stre	et and Numbe Stata)	er or Rurel	Route Number CON
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in	edical C	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, dete and manner steted.  1 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, of and manner steted.	te and place, end do, deeth occurred et	405/B ue to the cau the time, date	se(s) and ma	nnar as sta	ted
	To the Comp	We	29c. License number O.C.M.			l. Date signed		
	R	`	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  MANAGEMENT BALTS  ALTERNATION OF THE PENN STREET BALTS	IMORE, M	ARYLAN	D 2120	1	
	Sta Registi	re	31. Dete filed (Month, Day, Year)  NOV 1 7 1999  Server & Signeture  Aparts	ív .				

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AMEN	IDED	ITEM #8	PEF	State of Maryland / Department of Health and N FH G778 12/27/99 AH <i>Certificate of Death</i>		iene 99 9. No.	36043
	ľ	Physic		Decedent's Name (First, Middle, Last)  James Gordon Ebaugh	2. Date of Death Month Nov. 14	Dey	3. Time of Deeth
		/Medi Examir		4a. Fecility Neme (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death	4c. County o	
		Funeral		3907 Roland Avenue  8altin 5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs.		N/A	
		Director		216-28-0484 1XM 2 F 66 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, 11 - UNK	-1932	9. Birthplece (State or Foreign Country) Baltimore, MD
		yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		h the Maryland r 28a-f ehow	Director	Maryland N/A Baltimore			1 X Yes 2 □ No
		with the or 2		10e. Street end Number 10f. Zip Code	10	og. Citizen of WI	
		death	Funeral	3907 Roland Avenue 21211  11. Marital Status	ecify Yes or No-		- American Indien,
	20	2 should be filed within 72 hours after death with the Maryland end Mentel Hyglene.  Is marked other than "natural", or items 23a or 28a-f show reumatic event, the Medical Evancine must be notified at	by Fu	1XX Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2XX No Specify:	nicari, etc.)	Specify:	, White, etc.
	21215-0020	72 hour	ted b	15. Decedent's Education 16e. Decedent's Usual Occupation		16b. Kind of Bus	White iness/Industry
	121	within 7	Completed	(Specify only highest grede completed)  Elementary/Secondery (0-12)  College (1-4or 5+)  Give kind of work done during most of work life. DO NOT use retired)	ang	Amousia	an Chandaud
		Hygle other t	Be Co	Unknown Inventory Controller  17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N		an Standard
	Maryland	Mente Mente arkad atic ev	To B	Ebaugh  19e. Informent's Name/Relationship ( <i>Type, Print</i> )  19b. Meiling Address ( <i>Street end Number or Run</i>	Hetheri	ington	
	Mar	d 2 sh th end 7 Is m treum					
	ore,	permit. Pages 1 end 2 should be filled within 72 hc Depertment of Health end Mentel Hyglene. Introportant: If Itam 27 is marked other than "natur any injury or other treumatic event, the Medical ance.	2 2	Herbert S. Steinberg Friend 1 Quimper Ct. Apt. 3A  20a. Method of Disposition  20b. Place of Disposition (Neme of commetery, crematory or other place)			21208-3070 City or Town, Stete
	Baltimore,	t. Pag tment tant: If tury o		4 Donetion 5 Other (Specify)  Balto-Washington Crematory	11/16/9	9 Laure	l, Maryland
	Bal	Depermine Deperm		21. Signature of Funeral Service Ucehsee 22. Name and Address of Facility  Burgee-Henss-Seitz	z Funeral	l Home,	Inc.
				Burgee-Henss-Seitz 3631 Falls Road, I and the death. Do not enter the mode of dying, such es cerdiac mode, or heart or res. List only one cause on each line.	Baltimore or respiretory erre	e, Marý] est,	Approximate
-		Physician					Intervel Between Onset end Death
	1	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)  a.   UNC CANCER  Due to (or es e consequence of):			3 months
		P #	Iner	Due to (or es e consequence of):			3 months
	6	cete be executed physician end s the buriel-transit	dical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying			1210
	68760,	te be e ysician se bunie	ical	Ceuse (Diseese or injury that initieted events			
Z	x 68	5 00	w w	resulting in deeth) Last			
CA	Box	deeth certifi e ettending ed for use es	Iclan	Part II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.	025 Bld sol	h	ribute to the cause of deeth?
Bos	, P.O.	es that the deeth cer igned by the ettendin be deteched for use	by Physician/M	Part ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.	238. Did to		3 Probably 4 Unknown
	Division of Vital Records,	been s	Completed b		24a. Wes er perform		24b. Were eutopsy findings eveileble prior to completion of ceuse
	Re	The law ate has page 2	ошо		1□ Ye	s MNo	of deeth?  1 □ Yes 2 □ No
	/ital		BeC	25. Was case referred to medical examiner?			
	of	this el di	- To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Ho	28d. Describe ho		
	ion	nding Jath. r: After se funer	ation	27. Manner of Deeth    28e. Date of Injury   28b. Time of Injury	200. DOGONDO NO	w injury occurre	v
	Divis	al or Atte s efter de l Diracto d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number , State)	r or Rural Route Number,
		To the Hospital or Attending I within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier (Check only one)  Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and place, and manner steted.	end due to the ce red et the time, da	use(s) end man ite end plece, er	ner es steted. nd due to the ceuse(s)
		To the To the	Me	29b. Signature end title 29c. License number	29	d. Dete signed	(Month, Dey, Yeer)
		1		NO. 1044944		11/18	,/99
		30		30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  STANCEY Waster 3333 Nonsh carlost 57n	EET 1	3214	none May lyndas,
		Sta	ite	31. Date filed (Month, Day, Year)  32. Registrer's Signature	1	אינונו ניי	In C. I. A Liter of A

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM # 13 PER FH G778 12/27/99 AH Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** NOVEMBER 12, 1999
pation of Death 4c. County of Death LUCINDA 10:42 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) **Examiner** BALTIMORE SECOURS NIA HOSPITAL If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 212-22-4966 1 □ M 20 F APRIL 04, 1919 SOUTH CAROLINA Director Usual Residence of Decedent 10a. Stata 10b. Counts 10c. City, Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at 1 Yes 2 □ No Director MARILLAND 10e. Street and Number 19g. Citizen of What Country? 6 CHELSEA USA TERRACE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herra: 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yas 2 🕱 No If Yes, Give 1 ☐ Never Married 2 ☐ Married natural', or 21215-0020 1 ☐ Yes 2√ No Specify: à BLAC 3€ Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Bustness/Industry Pagas 1 and 2 should be filed within I Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) ASSISTANT FOREST PARK SENIOR (ENTER PPS Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 1ACK OX JAMES ALMENA operiment of Health and Important: if item 27 is many injury or other traumant pages. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23/2 CHELSEA TERRACE, BALTIMORE, MD. 2/2/6
toe of Disposition (Name of Date 20c. Location - City or Town, State ROSL EPRS (DAUGHTER) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS CEMETERY 111-18-99 BALTIHORE, MARYLAND TOSEPH H, BROWN JR. FUNERAL HOME 2140N. FULTON AVE. BALTIMORE, MD. 21217
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest,

Approximate ure of Funeral Service License 22. Name and Address of Facility **Physician** ial FN BARCTIO /Medical Immediate Ceusa (Finat disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 triknown Records, ò 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Affar Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A Invastigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò

**DHMH 16 Rev 6/95** 

Hospital

8

State Registrar

Medical

DRJOHN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRIOR 151,721 4 GR GATE NOL 2 Registrat's Signature

31. Date fited (Month, Day, Year) NOV 1 7 1999

29a. Certifier

(Check only

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c. License number

2000299 68

29d. Date signed (Month, Day, Year)

November

FAR TITUDA

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 36045

				Cert	tificate	of Death		F	Reg. No.	00	0,0	
Dh!-!	1. Decedent's Nama (First, Middla, L	Last)						Deta of Dea Month	ith Day	Year 3	. Time of Death	
Physician /Medical	Katherine M. I	Foertsch					NC	VEME	ER 4, 1		:11AM	
Examiner	4a Facility Nama (If not institution, g		C+-			4b. City, Tow		n of Death	, , , , , , , , , , , , , , , , , , , ,			
	Saint Joseph	Medical	Lente	r		Land Street Land	wson			Baltim	ione	
uneral irector	212-07-8039	. Sax 7. Ag	a (In yrs. last i	birthday) Yrs.	If Under 1 Months D		Min. (	Data of Birth Wonth, Day ct 31	, Year)	9. Birthplace Country) unkn	i (Stata or Fora OWN	
	Usual Rasidance of Decedant  10a. Stata 10b. County		10c. City, To	wn or Loc	ation					104	insida City Lim	
be notified at Director			100. Ску, те	AWIT OF LOCA	anori						1 Yas 2	
be notified Director	MD Ball 10e. Street and Number	ltimore	Ва	ltimo		**			10g. Citizen of What Country?			
Dir Bee					10f. Zip Co							
eral les	9640 Dixon Aven	12. Was Decedent	Fuer in II C	21234  13. Was Decedent of Hispanic Origin? (Sp if Yas, specify Cuban, Mexican, Puarto			-2 /Cassitu	Van au Na		USA e - American I	ndian	
Examiner must by Funeral	11. Marital Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?			Yas, specify		Puarto Rica	o Ricari, atc.) Black, \		ck, Whita, atc.	, Whita, atc.	
completed	15. Decedent's	Education	16	Sa. Decede	ent's Usual C	ccupation	ion 16b. F		16b. Kind of Bu	usiness/Indust	ry	
and de	(Specify only highast g Elementery/Secondery (0-12)	College (1-4or !	5+)	life. Do	O NOT use	lone during most of etired)	or working	nking				
E HO	12				Нс	usewife			unknown			
avent, I Be Cc	17. Fathar's Nama (First, Middla, Las	st)				18. Mother	18. Mother's Nama (First, Middla, Maidan Sumama)					
rksed ffic s To E	JOS	SEPH J. Doy	le				1	Elizabeth Laurer				
E I	19a. Informant's Neme/Ralationship		.11	9b. Meiling			Number or Rural Routa Number, City or Town, Stata, Zip Code)				de)	
27.1 er fr	Joseph F. Foerts	ch/husband			9640	Dixon Av	re, Ba	ltimo	e, MD	21234		
ury or oth	20a. Mathod of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Othar (Special Control of Control				ition (Nama atory or othe		Da	ate	20c. Location -	City or Town,	Slala	
any inju	21. Signature of Funeral Sarvice Lice RONALL S. W	ade, Direct	tor			ddrass of Facility natomy B re, MD	oard, 21201	655 V	V. Balt:	imore S	Street	
	23a. Part1. Entar tha disaasa, or co	mplications that caused	tha daalh. D					piratory an	rast,	Ap	proximata	
sician	shock, or haart failura. List onl	iy ona causa on aach ii	Nat.								arval Batween sat and Death	
edical	Immediata Causa (Final disaasa or condition	RESPIR	ATORY	FAI	LURE						AYS	
miner	resulting in deeth)	Θ	Dua to (or as	a consequ	ieuce ot).					1		
ě –		PNEUMC								E	AYS	
in and ial-transit Examiner	Sequentially list conditions.	b	Dua to (or as	a consequ	ence of):							
	Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated evants	CHRONI	c. CHRONIC OBSTRUCTIVE FULMONARY  Dua to (or as a consequence of):						Y DISEASE			
ng physician and as the burial-transit Aedical Examir	Cause (Diseasa or Injury that initiated evants rasulting in death) Last	C										
d by the attanding atached for usa a Physician/M		d					7. 2.					
the a	Part II. Other significant conditions	contributing to death b	ut not rasulting	in tha und	derlying caus	a given in Part I.		23b. Did to	obacco use co	ntribute to the	cause of de	
Phy Phy								150	res 2□No	3 Probab	ly 4□Unkr	
b ed							_	- /		1		
page 2 should								24a. Was a parfor	an autopsy med?	availal	autopsy findin ole prior to	
has be ge 2 sh mple							-			of dea	etion of causa th?	
page page								1 🗆 Y	as 2 No	1 🗆 Ya	as 200	
certificate rector, pag	25. Was case rafarred to medical					26. Place of	of Death (Ch	eck only or	na)			
direction of	axaminar? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/0	Outpatient	3□ DOA	Other: 4 Nurs	sing Homa	5 Rasid	ance 6 Oth	ar (Specify)		
	27. Mannar of Death  ↑ Natural 5 ☐ Pending	28a. Data of Inju (Month, Da	ry 28b	Tima of Injury	28c.	injury at Work?	28d.	Describe h	ow injury occur	red		
ar this heral di	1 Natural 5 ☐ Pending		, , , ,	n yor y	М	1 Yas 2 N	0					
r: Aftar this se funeral ation: T	2 Accidant invasligeti	3 Suicida 6 Could not be determined 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)							281. Location (Street and Number or Rural Routa Numb City or Town, Stata)			
Il Director: After this od in by the funeral of Certification: T	2 ☐ Accidant invasligeti 3 ☐ Suicida 6 ☐ Could not	d Zea. Place of inj	c. (Specify)									
ne Funeral Director: Attar this pletely filled in by the funeral edical Certification: T	2 Accidant invasligeti 3 Suicida 6 Could not determine  29a. Certifier 1 Certifying P	d Zea. Place of inj	of my knowled	ge, death o	occurred at to	he time, date and my opinion, death	place, end of	dua to the c	eusa(s) and me date end place,	ennar as state end due to lhe	d. e cause(s)	
To the Funeral Director: After this completely filled in by the funeral Medical Certification: T	2 Accidant invasligeti 3 Suicida 6 Could not determine  29a. Certifier 1 Certifying P (Check only 2 Medical Exa	building, at	of my knowled	ge, death cand/or inve	estigation, in	my opinion, death	place, end o	the time, o	date end place, 29d. Data signe	end due to the	e cause(s)	
he Funeral Director: After pletely filled in by the fune edical Certification	2 Accident invastigeti 3 Suicida 6 Could not determine  29a. Certifier (Check only one) 1 Certifying P	building, at	of my knowled	ge, death o	estigation, in	my opinion, death	place, end of occurred et	the time, o	date end place,	end due to the	cause(s)	
To the Funeral Director: After this completely filled in by the funeral Completely filled in by the funeral Medical Certification: T	2 Accidant 3 Suicida 6 Could not determine  29a. Certifier (Check only one)  29b. Signatura and titla of certifiar	Physician: To the best aminer: On the basis of and manner str	of my knowledd examination alled.	and/or inve	29c. L D31	my opinion, death	place, end o	the time, o	date end place, 29d. Data signe	end due to the	e cause(s)	
To the Funeral Director: After this completely filled in by the funeral Medical Certification: T	2 Accident invastigeti 3 Suicida 6 Could not determine  29a. Certifier (Check only one) 1 Certifying P	Physician: To the best aminer: On the basis of and manner sta	of my knowleds examination alled.	and/or inve	29c. L D31	my opinion, death cense number , 826	occurred et	the time, o	date end place,	end due to the	cause(s)	

NOV 15 1939 James D. Horston :

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 15, NOVEMBER 1999 3:08 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Saint Joseph Medical Center Towson If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dele of Birth (Month, Day, Year) Days Min. Months Hours 1 M 2 □ F 8 -05-473 Usual Residence of Decede 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7909 21234 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indien, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Specity: White 1□ Yes 2NNo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bysiness/Industry LIFTON Elementary/Secondary (0-12) College (1-4or 5+) upholstely COM. 17. Fether's Name (First, Middle, Last) 18 Mother's Nama /First Middle, Maiden Sumame Remian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Baltimore lementen 20b. Place of Disposition (Name of cemetery, cremetory or other) Dete 20c. Location - City or Town, State 20a. Method of Disposition Nov. 18 15 Burial 2 Cremetion 3 Removal from State Comodery 4 Donation 5 Dother (Specify) 1999 21. Signature of Fitneral Service Licen 22. Neme end Address of Fecility ineral Chapel Vaks se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, List only one cause on each line. 21234 Approximete Interval Batween Onsel and Death Immediale Cause (Final 2 DAYS PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of) 2 DAYS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2X No 1 ☐ Yas 2 No 26. Place of Death (Check only ona) 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

Physician/Medical Examiner

Be

Certification: To

**Physician** 

/Medical

Examiner

10e State

Funeral

Director

ahow

r than "natural", or items 23s or 28s-f ahor the Madical Examiner must be notified at

7 la markad other than traumatic avent, the M

permit. Pages 1 and 2 Department of Health a Important: If Itam 27 la any injury or other tra

Funeral Director

p

Completed

8

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland

lician and burial-transit The law requires that the death certificate be executed Box 68760, physician the buria 88 for USA P.O. | been signed by the a Division of Vital Records. Completed by page 2 certificate or Attanding Physician: director. After this funarai 24 hours after death.

Funeral Director: A the filled in by

Medical completely within 2 To the F To the

Hospital

State Registrar

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the tima, data end place, and due to tha cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data end place, and dua to tha cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

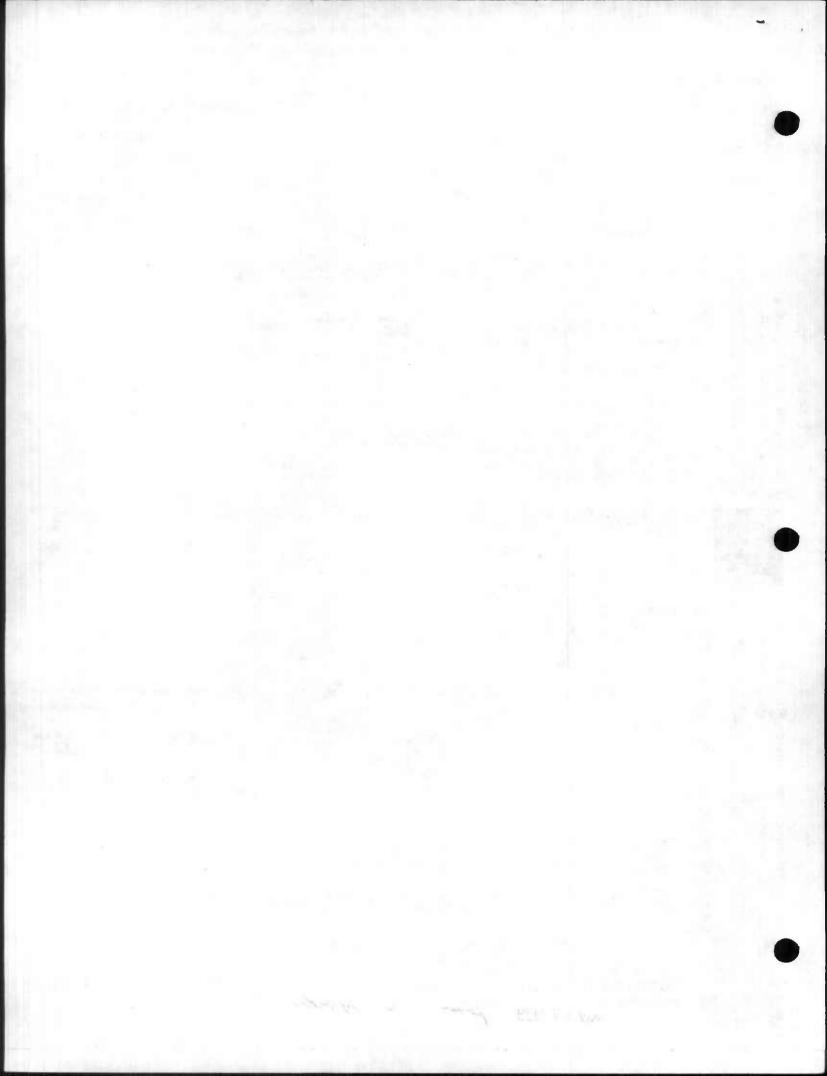
multa M.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 MEHTA,

D 0041410

JOGINDER P. 31. Date filed (Month, Day, Year)

32. Registrar's Signature sparks MMA'T 1 1377



AN	MENDED ITEM	#8 PER FH G777 11/17/99 AH	Certificate of Death	Reg. No.	30047
-	Dhucinian	Decedent'a Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physician /Medical	Kichard M. Freeze		NOV. 12 19	99 11:25 AM
	Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. County of	of Death
		Stella Maris Hospice	Timmilian	n Bald	imsee
	Funeral	5. Social Security Number 6. Sax 7. Aga (In yrs	last birthday) If Under 1 Yaar If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth 5/16/60 (Month, Day, Ybar)	9. Birthplace (State or Foreign Country)
ш	Director	216-84-6683 1XM 20F	39 Yrs. Mainti Suys 11841	Mapol 16, 1960	Maryland
	2	Usual Residence of Decedent			
	ahow d m		ity, Town or Location		10d. tnside City Limits
	the Meryla 28e-f aho notified at	Md Baltimore	Cockeysville		1 ☐ Yes 2 No
	or 24	10e. Street and Number	10f. Zip Code	10g. Citizen of W	hat Country?
	23a	10337 Malcolm Cieclo	21030	11.5	A
	fler death with the Mei r Herms 23s or 28s-f s Ther must be notified Funeral Director	11. Marital Status  12. Was Decedant Evar in the Armed Forces?	J.S. 13. Was Decedent of Hispanic Origin? (Sp tt Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	- Amarican Indian, , White, etc.
0	at a T	1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Giva	1 Yes 2 No Specify:		1 11 1
9	ral', o	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	TE 195 2 Jacks Specify.	Specify:	White
21215-0020	led within 72 hours after death with the Meryland ygiens.  In the Mexical Examiner must be notified at Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Occupation (Give kind of work done during most of work	ing 16b. Kind of Bus	siness/Industry
2	within ena.	Elementary/Secondary (0-12) Cottege (1-4or 5+)	life. DO NOT use retired)		Col
	TO LE U	12 2	DNIDDING DUDY.	Super	PRUN
pu	ntal Hygin dother avent, II	17. Father's Nama (First, Middla, Last)	18. Mother's Name	e (First, Middle, Maiden Sumame	)
yla	should by the Mental marked imatic a.	Kichaed 1. Keleze	Caro	ee M CRIC	idy
Maryland	2 sh end la ma	19a. Intorment'a Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, City or Town, S	State, Zip Code)
		Michael W. Stitler	110337 Malcolm Ciecl	e Cockeysvill	e. Md 21030
ore			Place of Disposition (Name of cemetery, crematory or other place)	Date 15 20c! Location - (	City or Town, State
E	Page nat: If Iry or	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ar Laure Comodery	1999 Baltim	DED MARIJANA
Baltimore,	permit. Page Department of Important: If any Injury or once.	21. Signature of Funeral Service Licensee	22. Name and Address of Fecility	ans Funeral	Chapa
m	Depariment of the part of the	Kaisda & La Jalla.	SCAD II AlacA AA	Danie runces	1 haires
		23a Part : Enter the diseasa, or complications that caused the dea	th. Do not enter the mode of dving, such as cardiac.	Dayumory II	Approximate
100	Dhusisian	shock, or heart tailure. List only one cause on each line.		or roophatory arroot,	Interval Between Onset and Death
	Physician /Medical /	Immediate Cause (Finat			
	Examiner	disease or condition resulting in death)  a. Acquired Im	mune Deficiency Syndrome		
	- L	Due to (	(or es a consequence of):		
	n and ial-transit	b			
	icate be executed physicien and s the burial-transit	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying	or as a consequence of):		
68760		Cause (Diseasa or Injury c.			1
88	ifficate be g physicie as the bur	resulting in death) Last	or as a consequence of):		
×	attending Ifor use as Clan/Me	d			
Bo	death e atten e atten e atten				
P.O.	the draw y	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part t.		tributa to the cause of death?
	that the ded by detac			1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ☐ Unknown
of Vital Records,	The lew requires that the less been signed as page 2 should be de Completed by F			24a. Was an autopsy	24b. Were eutopsy tindings
Ö	requirement			performed?	available prior to completion of cause
Šec	has bas and mpl				of death?
=	Se pag			1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
/ite	ysician: The I is cartificate hi director, paga To Be Com	25. Was case reterred to medicat examiner?		h (Check only one)	
)t				me 5 Residence 8 X Othe	
Z Z	is after death. Is after death. Is Director: After to death by the funers Certification:	27. Manner of Death 1 X Netural 5 ☐ Pending (Month, Day Year)	28b. Time ot Injury at Work?	28d. Describe how injury occurre	ed
9.0	Attending in death.  octor: After by the fune lification	2 Accident invastigation	M 1 Yes 2 No		
Division	after deeth. Director: After d in by the fune	3 ☐ Suicide 6 ☐ Could not be detarmined 28e. Place of Injury - At the building, etc. (Special Special		<ol> <li>Location (Street and Number City or Town, State)</li> </ol>	er or Rural Route Number,
	C ed Date				
	To the Hospital or Attanding Phyminia 24 hours after death. The Target of The Target of The Thompson and The The Thrompson and The Thrompson and The Thrompson and The Thrompson and Thr		owledge, deeth occurred et the time, date and place, ation and/or investigation, in my opinion, death occur		
	The He the Party of the Party o	one) and manner stated.	and a miroshigation, minip opinion, death occur	So at the time, bate one place, a	350 .00 00000(3)
1	within to the comple	29b. Signature and title of certifier	29c. Licensa number		(Month, Day, Year)
٥,	111	/47=	D43725	11/1	12/99
	UM	30. Name and address of person who completed cause ot death (Ite	m 23a) (Type, Print)		
	110/	DR. TARIQ MAHMOOD 2300 DULA	NEY VALLEY RD. TIMONIUM	MD WXXXX 210	93
		A D	THUNLUNG	TIN GOOD ALL TIO	J-J-

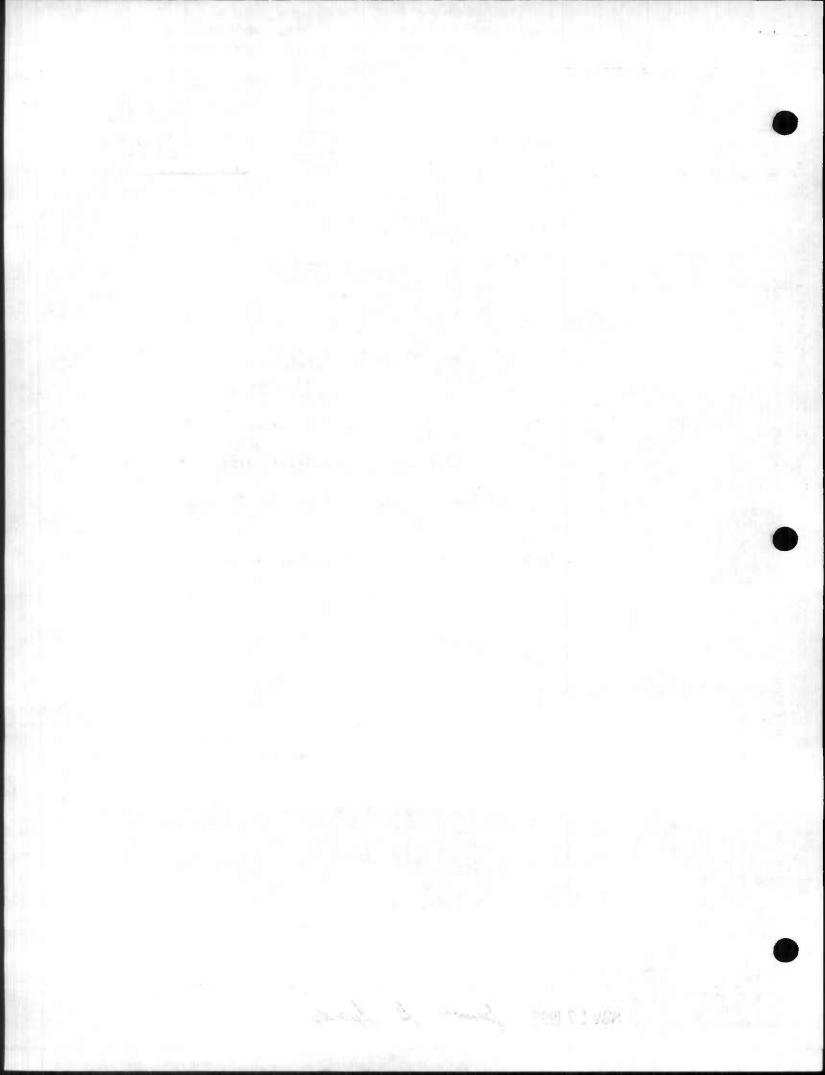
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

Registrar

NOV 1 7 1999

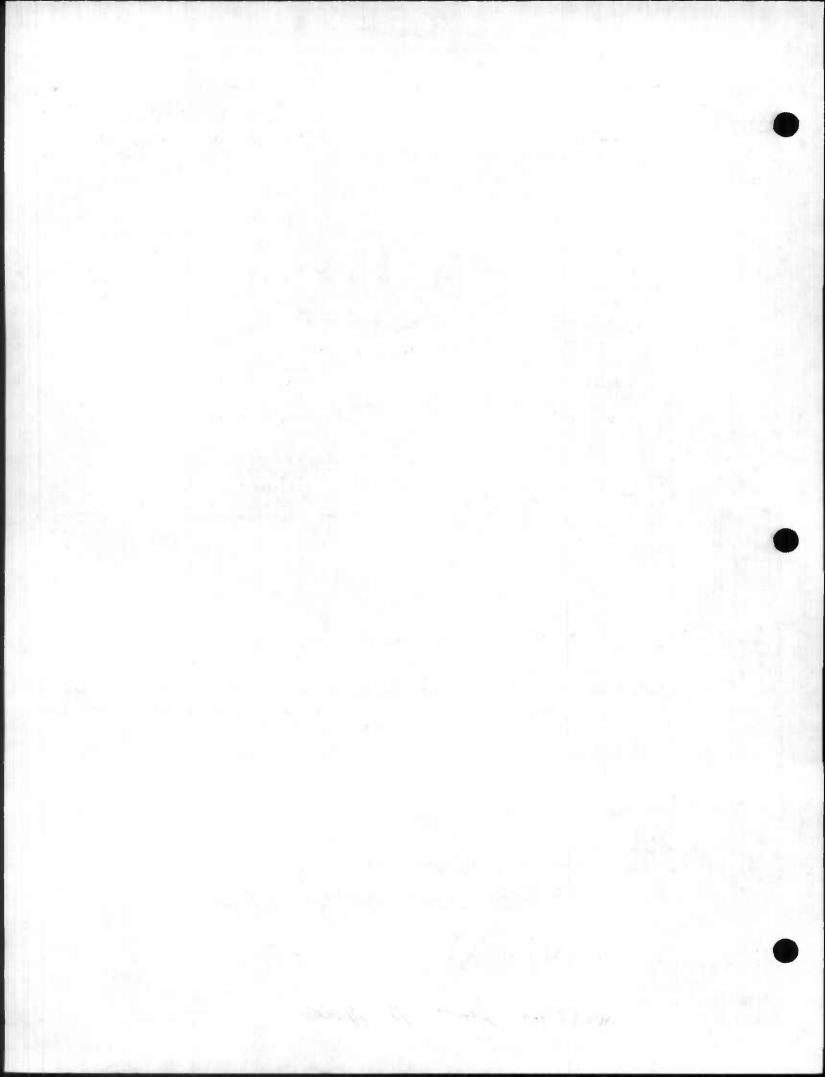


# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.	35048								
Physiciar	1. Decedent's Nama (First, Middle, Last)  Jerome Kent Fleming	2. Data of Death Month Day Yea									
/Medica Examine		November 15, 1999 r Location of Death 4c. County of De	7:45 am								
LXMIIIIC	13613 Creekside Drive Silver Sp										
Funeral Director	5. Social Security Number 143–22–0098  6. Sex 1	S. 8. Date of Birth (Month, Dey, Year) January 7,1931	Birthplace (Stete or Foreign Country) WV								
Mend **	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits								
Be-fal	MD Montgomery Silver Spring Maryland		1 ☐ Yes 2 No								
23s or 2	10e. Street and Number 1361.3 Creekside Drive 10f. Zip Code 20904	10g. Citizen of What United S	•								
15-0020 72 hours after deeth with the Marylend "natural", or flems 23s or 28s-f show added Evantines must be incitited at	11. Marital Status  1 Never Married  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decadant Evar in U.S. Armed Forcas? Unk.  Armed Forcas? Unk.  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue Yar or Dates:		mencan Indian, hite, etc. White								
	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4or 5+) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) Divisional Staff Manager										
Hygie de La	12 4 DIVISIONAL Staff Manager 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	eme (First, Middle, Maiden Sumeme)	actors								
aryland 2121 should be filed within nd Mental Hygiene. marked other than '	Pliny E. Flaming Virg	inia Adkins									
, Mar and 2 sho leith end I 27 is me or traum	19a. Informant's Name/Reletionship (Type, Print)  Barbara Fleming / Wife 13613 Creekside Drive, S										
Baltimore, Maryland 2121 permit. Peges 1 end 2 should be filed within Department of Heelth end Mental Hygiene. Important: If Nem 27 is marked other than any injury or other traumatic event, the Medica.	20a. Method of Disposition  1 Burial 2 Cremation 3 Demoval from Stata  4 Donation 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other piece)  Fairview Cemetery November 19, 1999  Cape May Co										
Balti Permit. Depertur Importa any inju	21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Fecility Charles L. Stevens Fur 1501 East Fort Avenue,	peral Home, Inc.	1230								
Physician	23a. Part1. Enter tha disease, or complications that caused the death. Do not anter tha mode of dying, such as cardishock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death								
/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death)  a. Uremia  Due to (or as a consequence of):		3 Weeks								
nsit	b. Diabetes Mellitus		Years								
68/60, ficeta be axecuted physicien and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										
BOX 688  attending phy for use as the											
at the death certification of the death certification of the attending etached for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribu	ute to the cause of death?								
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0 > 10 =		24a. Was an autopsy performed?	b. Were autopsy findings available prior to completion of cause of death?								
The The Page		1 □ Yes 2XXXo	1 ☐ Yes 2 ☐ No								
OT VITAL Kel Physician: The lev this certificate hes ral director, page 2	examiner? Hospital: Other	eath (Check only one)									
0 5 5 7	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5℃ Besidence 8 Other (S 28d. Describe how injury occurred	pecity)								
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= x2=c	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	281. Location (Street end Number or City or Town, Stete)	Rurel Route Number,								
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cart		(Check only 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s)									
ro the routher comple	29b. Signature and the of century 20c. License number	29d. Data signed (Mo	onth, Dey, Year)								
	30. Name and address of person who complated cause of death (Item 23a) (Type, Print)	November	15, 1999								
10	Mark S. Rosen, M.D., 39411 Ferrara Drive, Wi	neaton Marvland	20906								
State Registrar	31. Data filed (Month, Day, Year)  NOV 1 7 1999  32. Registrar's Signature  Space  Spa										

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Daeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Daeth Month Day Yae 6:50 P.M. MARY C. **FOSTER** NOVEMBER 9, 1999 4e Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth ANNIE ARUNDEL, CO. MARINER HEALTHCARE OF GLEN BURNIE GLEN BURINE 9. Birthplece (State or Foreign Country) ALABAMA If Undar 1 Yaar 8. Date of Birth Month, Dey, Yeer) AUG 8,1912 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1□ M 2√ F 87 156-12-3664 Usuel Residence of Decedent 10d. Inside City Limits 10a State 10h Count 10c. City. Town or Location 1 Yes 2 No MARYLAND BALTIMORE 10f. Zip Coda 10g. Citizen of Whet Country? 10e. Street end Number 2303 LYNDHURST AVE. 21216 USA 12. Was Decedent Evar in U.S. Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 况 No Specify: Specify: AFRO. AMERICAN 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE HOSPITAL 12 18. Mother's Neme (First, Middle, Maiden Surneme) 17 Fether's Nama (First Middle Last) JIM **FOSTER** LESLIE **FOSTER** 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 2303 LYNDHURST AVE, BALTIMORE, MARYLAND 21216-2014 DIMETRA FOSTER 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Removel from Stata 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 11/11/99 CATONSVILLE, MD. 21. Signeture of Funeral Service Licensee ESTEP BROTHERS FUNERAL, P. A. EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death )ementa 415 Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of) Sinus Syndronne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Lest Due to (or as e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24a. Was an autopsy completion of cause of deeth? 20 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 27 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 3□ DOA 27. Menner of Deeth 1 Naturel 28b. Time of 28d. Dascribe how Injury occurred

/Medical Examiner physician end the burial-transit The law requires that the death certificete be axecuted attending phy

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Division of Vital Records, P.O. Box 68760,

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**Physician** 

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Instit if ten 27 is marked order than "natural", or items 23s or 28s-f show into the traumatic event, in shedical Experiment name to retified at my or other traumatic event, in shedical Experiment and to retified at

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai à Completed Be 2 Certification:

25. Wes case referred to medicat examiner?

28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending invastigation

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

6 Could not be determined 4 Homicide 29e. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s)

prospermal buildy Site 200 Cley Brown

(Check only one) 29b. Signeture end title of cartifie

2 Accidant

3 ☐ Suicide

29c. License number

29d. Date signed (Month, Dey, Year)

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11-10-99

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

misze . m. Nuscitee OALL word 7845 31. Dete filed (Month, Day, Year)

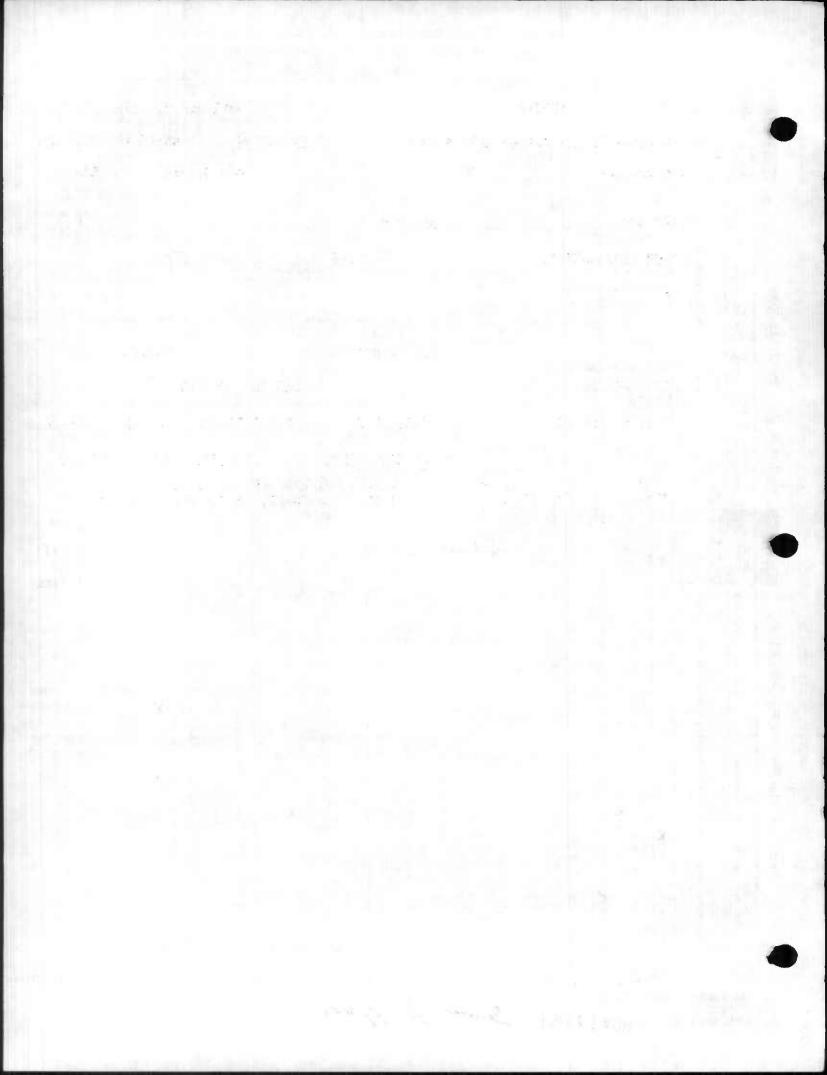
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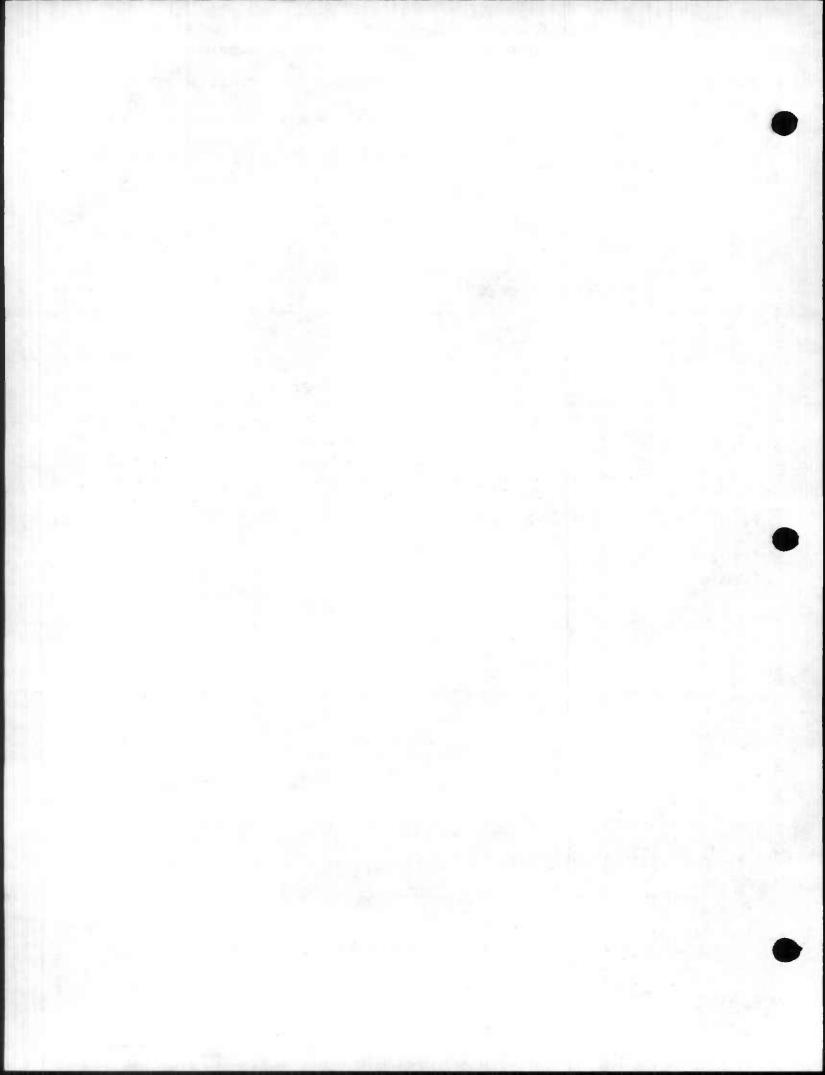


### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 13, 1999 HAROLD K. **GOLDMAN** 10:45 AM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIKESVILLE NURSING HOME BALTIMORE BALTIMORE If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□ F 215-10-1813 Director 85 DEC.28,1913 Usuel Residence of Decedent the Maryland 10a. Stete 10b Counts 10c City Town or Location 28a-f show notified at 10d. Inside City Limits 1 Yes 2 □ No N/A BALTIMORE Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 6 3631 GLENGYLE AVENUE ne 23a #A-6 21215 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No It Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) filled within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) PHARMACY PHARMACIST 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental 14 and: If Rem 27 is marked oth lury or other traumstic event 89 **GOLDMAN ABRAHAM** ESTHER SONNER 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CELIA GOLDMAN / WIFE 3631 GLENGYLE AVE. #A-6 - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method ot Disposition 20c. Location - City or Town, Stete 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from Stete Department or mportant: If 4 □ Donetion 5 □ Other (Specify) ARLINGTON CHIZUK AMUNO 11/15/99 BALTIMORE, MD 21. Signature of Fune Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23e. Pert1. Enter the disease, or complication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Muocar day Examiner Due to (or es e consequence of): Examiner the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence ot) USB 85 1 P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 21 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? page 2 should Completed 24a. Was an eutopsy performed? certificate hes 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Divining Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendenthin 24 hours after deat To the Funeral Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 4 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 4000 MO 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture State Registrar **DHMH 16 Rev 6/95** 

**ORIGINAL** 



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Dete of Deeth Month erde/ 0:50 November 4a Facility Name (I not institution, giva street and number) 4c. County of Death 4b, City, Town, or Location of Death lumbia porien Howard VUrsing f Under 24 Hrs. 5. Social Security Number Aga (In yrs. lest birthdey) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex Birthplaca (Stete or Foreign Country) 1□M 2√x Months Deys Hours 83 218-03-6864 Aug. 26, Md. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 Dantes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21207 3714 Sylvan Drive USA 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Wes Decedant Evar in U,S. Armed Forces? Black, Whita, atc. 1 □ Yas 🎗 🖸 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 Yes 2 to Specify: Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) College (1-4or 5+) 6th Grade Foster Care Parent Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Jarvis Lucy V. Harris 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 12600 Golden Oak Drive Ellicott City, Md. 21042 John E. Gordon son 20b. Plece of Disposition (Name of cematery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Nov. 17 Laurel, Md. Md. National Mem. Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Line 2501 Gwynns Falls PKWY Baltimore, Md. 21216 un 23a. Per 1. Entar the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each time. Approximete Intarvel Between Onset end Death Immediata Causa (Final diseese or condition rasulting in death) Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Ceuse (Disaase or injury that initiated avents resulting in daath) Last Due to (or es a consequence of) reitension Dua to (or as a cons milen rent APARO 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☑ Unknown emento a 24b. Were autopsy findings eveilable prior to completion of cause of daath? 24a. Wes an eutopsy performed? 2 No 1 Yas 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one) Hospital: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner burial-transit Attending Physician: The law requires that the death certificate be executed and P.O. Box 68760, physicien USB as be detact 2 Division of Vital Records. **page 2** this certificate director. funeral After To the Hospitat or Attendin within 24 hours after death. To the Funerel Director: At completely filled in by the fu

**Physician** 

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Department of Heelth ar Important: If Item 27 le eny Injury or other trau

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21215-0020

altimore, Maryland

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Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Be Completed 25. Wes case referred to medical examiner? 1 Yas 2 No Certification: To 27. Manner of Deeth 1 Neturel 2 Accidant Could not be determined 3 ☐ Suicide 28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To tha best of my knowledga, daeth occurred at tha tima, data and place, and due to tha cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date end place, end dua to the cause(s) end menner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) mmy we

State Registrar

**DHMH 16 Rev 6/95** 

1999 NOV 17

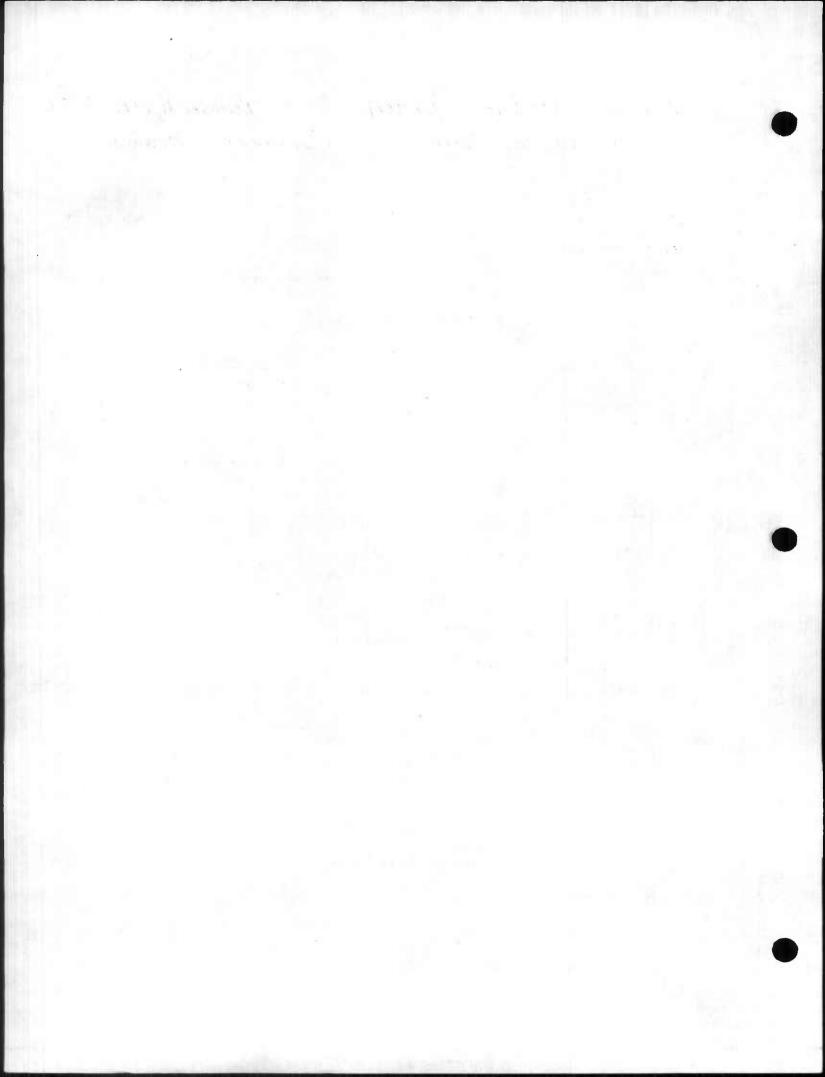
ORTEN 32. Registrar's Signeture

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) tome; Howard, mi

November 15, 1999.

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31. Date filed (Month, Dey, Year)

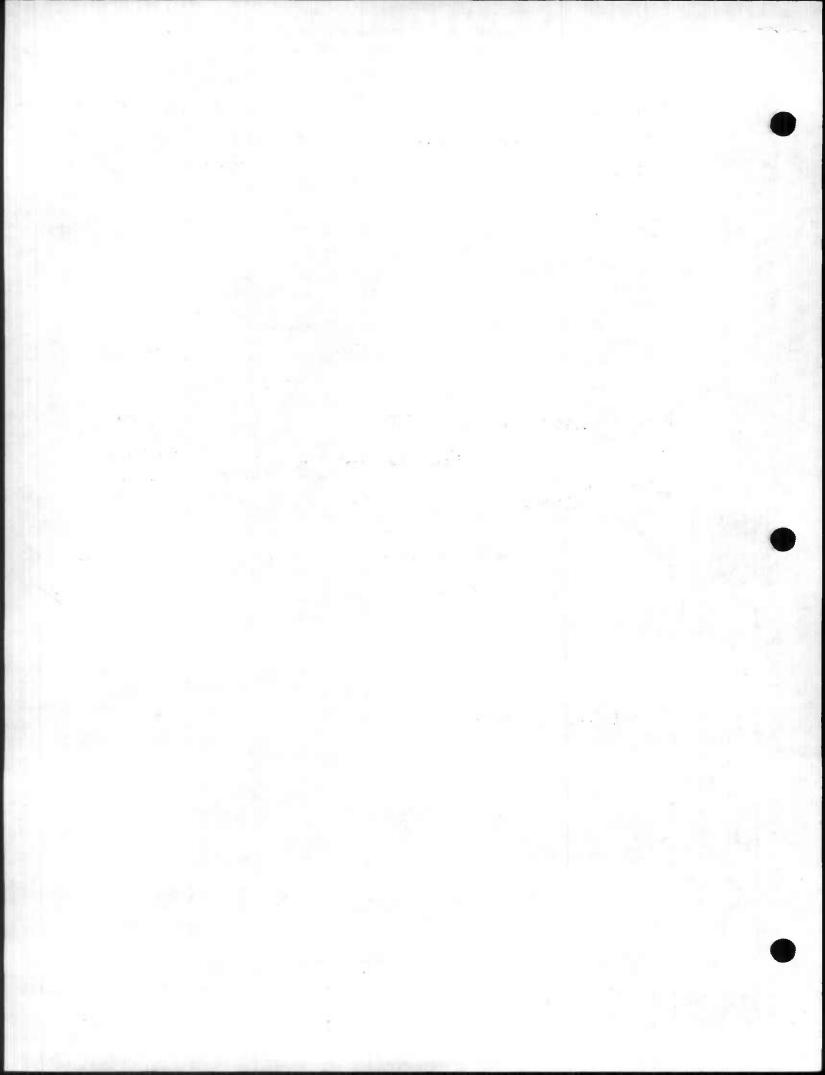


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State of Maryland / Department of Health and Mental Hygiene

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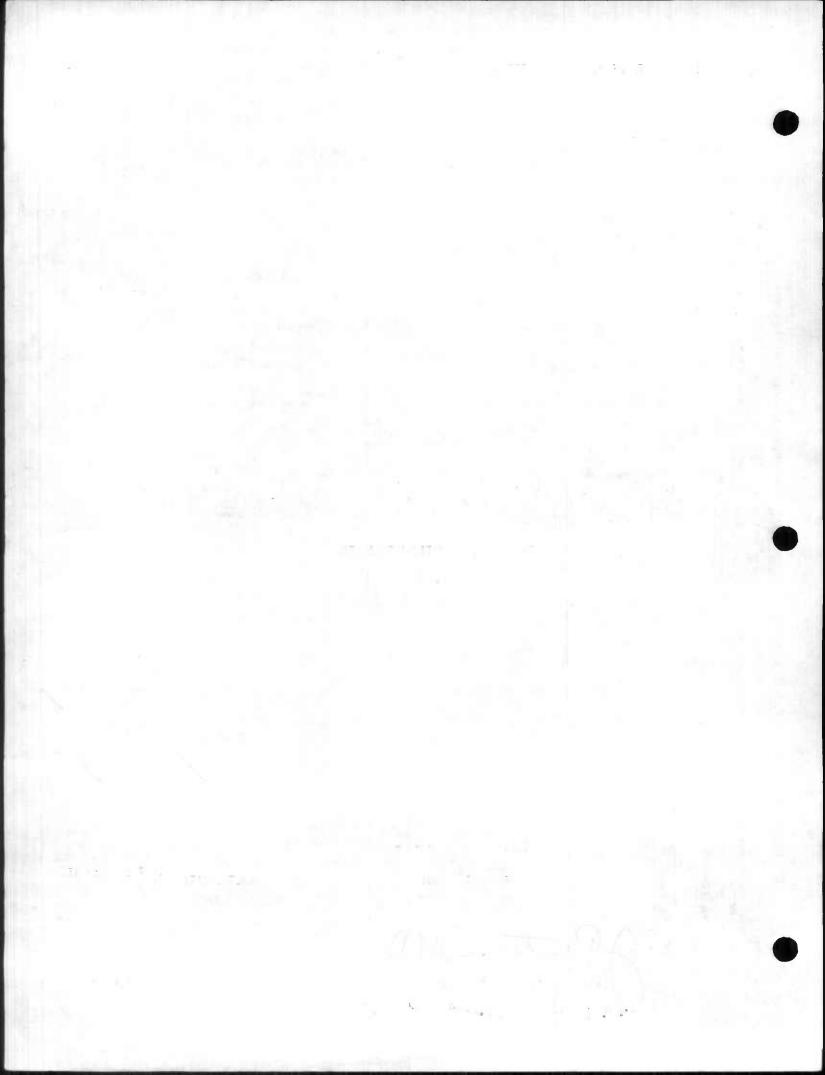


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			1. Decedent's Name (First, Middle, La	st)					2. Date of De		V	3. Time of Death	
	Physic		MICHAEL S.	GUEST					NOVEMBE	ER 14,19	99	8:18P.M.	
	/Medi Examii		4a Facility Name (If not institution, giv	re street and number)		_	- 4	lb. City, Town, o	or Location of Deat				
			UNION MEMORIAL HO	SPITAL				BALTIM	ORE	NT	/A		
	Funeral		Social Security Number 6. 8		rs. last birthday	) If Under 1	1 Year Days	If Under 24 H		th		ace (State or Foreign	
п	Director	H	214-80-3000	XDM 2□F 39	Yrs.	MOINTS	Days	Hours IVI		2,1960			
	pu »		Usual Residence of Decedent  10e. State 10b. County	100	City, Town or L	conting					140	led tourists Other triming	
	ahov a box	<u> </u>			•						,,,	od. Inside City Limits 1 ☐ Yes 2 ☐ No	
	Ne W	ecto	MARYLAND N/	Α	BAL	r I MORI				10.00		X	
	with p	ō	10e. Street and Number	AD CMDHHM		10f. Zip (		1010		10g. Citizen of		ny?	
	within 72 hours after death with the Meryland ene, than "natural", or Hems 23e or 28e-f ahow he Medical Examinat must be notified at	Funeral Director	1510 HOMESTE		116 12	Was Daned		1218	(Casaita Van es Ne	U.S.	A . ce - America	n Indian	
	Per de	5	11. Marital Status	12. Was Decedent Ever in Armed Forces?	10,5.	If Yes, speci	ent of H	ispanic Origin? in, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Bla	ck, White, e	Mc.	
20	rs aff	by F	1 Never Married 2 Married 3 Widowed 4 ☑ Divorced	1 Yes 2 No If Yes, Give X Year or Dates:		1□ Yes 2	No No	Specify:		A F R	O-AMI	ERICAN	
21215-0020	n 72 hours natural', edical Ex	8	15. Decedent's Ed		16a Dec	edent's Usual	l Occup	ation		16b. Kind of B	usiness/Inde	ustry	
15	in 72 h	Completed	(Specify only highest gra	ide completed)	(Giv-	B kind of work DO NOT use	k dona d e retired	during most of w	vorking				
212	filed within Hygiene. other than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	BRIG	CKLAY	ER/	cabine	t maker	HOME	IMPRO	OVEMENT	
	e filed al Hygic other vent, th	BeC	17. Father's Name (First, Middle, Last,					18. Mother's N	ame (First, Middle	, Maiden Sumar	ne)		
la	should be nd Mentel marked o	0	GEORGE A. GU	EST				RU	TH FONS	H FONSECA			
Maryland	~ = _ =	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Addrass (Str.			and Number or	Rural Route Numb	er, City or Town	, State, Zip	Code)	
	Health Pm 27 ther tr		RUTH DORSEY/	MOTHER	701	MELV	ILL	E AVE.	BALTO,	MD. 2	1218		
ore			20a. Method of Disposition		. Place of Disp	osition (Name	e of her plac	e)	Date	20c. Location	- City or Tov	vn, State	
E			1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		T. ZIC				ov.20,1	999 BA	LTO.	MD.	
Baltimore,	permit. Peg Department Important: I any injury c	7	21. Simulare of Funeral Service Licer		2	22. Nama and	Addres	ss of Facility					
0	89E 8		Marnodine	71 Acu					GGS FUN N STREE			0. 21213	
	Physician /Medical Examiner	ler	Int. Enter the diseasa, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ETHANOL AND NA		NTOXICAT		g, such as cero	ac or respiratory a	nest,		Approximate Interval Between Onset and Death	
	be executed slcien and buriel-transit	Examiner		b	o (or as a conse			_			i		
ń	exect in and isl-tra	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	Dua to	o (or as a conse	rquence ot):							
3760,	W 2 0	Ca	that initiated events	C. Due to	(or as a conse	dilence of).							
99		P	resulting in death) Last		(5. 40 4 55.15)	400.000.7.							
Box	deeth certifice e attending ph ed for use es ti	2		d									
	0 0 0	Physician/Mec	Part II. Other significant conditions of	ontributing to death but not i	rasulting in the	undarlying ce	use giv	en in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?	
P.0	thet the de ad by the a	بر	-						10	Yes 2□ No	3 □ Prob	ably 4@Unknow	
	es the	by							-				
Records,	v requires thet the been signed by th should be detech									an autopsy omed?		re autopsy findings iilable prior to	
BCC	× 2 × ×	pie							-		CON	npletion of cause leath?	
Œ	0 - 0	Completed							10	Yes 2 No	1 🗓	Ves 2□ No	
Vital		Be	25. Was cese ratarred to medical		_			26. Place of D	eath (Check only	one)			
of V	5 00 0	10	axaminer? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	ent 3 DO	A Oth	er: 4 Nursing	Home 5□ Resi	dence 6 □Ot	her (Specify	)	
	ding Ph h. After th funeral		27. Manner of Daath 1 □ Natural 5 □ Pending	28a. Data of Injury (Month, Day Year,	28b. Tima	ot 28	Bc. Injun	y at k?	28d. Describe	how injury occu	rred		
Ö	Attending or deeth. octor: After by the fune	atic	2 ☐ Accidant investigation	11/14/99	unknowr	M		Yes 2 No	U	NKNOWN			
Division	or Attendation Director:	Certification:	3 ☐ Suicide 6 ☑ Could not b 4 ☐ Homlcida datarmined		t home, farm, s	treet, factory,	office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural	Route Number,	
	rs after or led in led in			FOUND IN					BALTO. C	ITY, MD.	/ E. 28	th St.	
	To the Hospital or Attending within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fune.	edicai		ysician: To the best of my k									
	the F the F the F	8	one) A	and manner stated.									
	To the vithin 2 To the comple	Σ	29b. Signature and title of certifier	-	118	29c.	Licens	e number		29d. Date signe	ed (Month, E	Jay, Year)	
			1 Street	Manu	10(-J	7	O.C	.M.E.	r	NOVEMBER	15,1	999	
			30. Name and oddress of person who	completed cause of death	tem 23a) (Type								
	$\sim$		Josep			111 P€	enn	Street,	Baltimo	re, Mary	land	21201	
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 1 7 19	32. Registrar's Sig	pnature &	por	ak.	2					

Re Re



for usa as or Attending Physician: Medical Certification: To within 24 hours after daath.

To the Funeral Director: After this complately filled in by tha funaral of

Records,

Division of Vital

Hospital

To the P within 2 To the P

that inflieted events resulting in death) Lest	Dua to (d	or as a consequence o	of):				
Pert II. Other significant conditions co	ntributing to death but not re-	sulting in the underlying	g caus	e given in Pert I.		ld tobacco use co	ontribute to the cause of death?
						es en eutopsy rformed?	24b. Were eutopsy findings evailable prior to completion of cause of death?  1 Yes 2 No
25. Wes case referred to medical	26. Placa of Deeth (Check only one)						
examinar? ★S Yas 2□ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)						
27. Manner of Death  Natural 5 Pending  Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury et Work? 1 Yes 2 No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				fice	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)		
	sician: To the best of my knot iner: On the besis of examine and menner steted.						
29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)	

O.C.M.E.

KORGU 111 Penn Street, Baltimore, Maryland 21201

3. Time of Death

1255 PM

Birthplace (State or Foreign Country)

MO

10d. fnside @ity Limits

1 2 Yes 2 No

Year

NIA

BLACK

21229

NOVEMBER 15, 1999

Approximata Interval Between Onset end Death

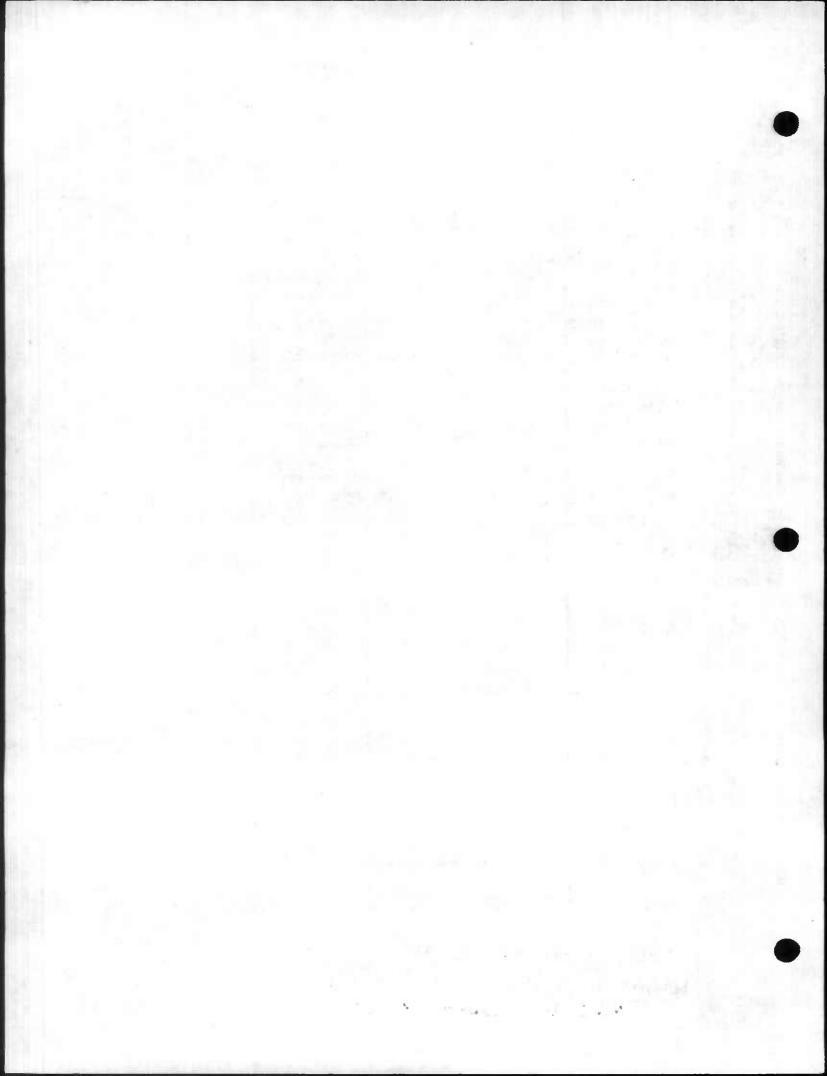
Registrar **DHMH 16 Rev 6/95** 

State

MARIAMAS

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

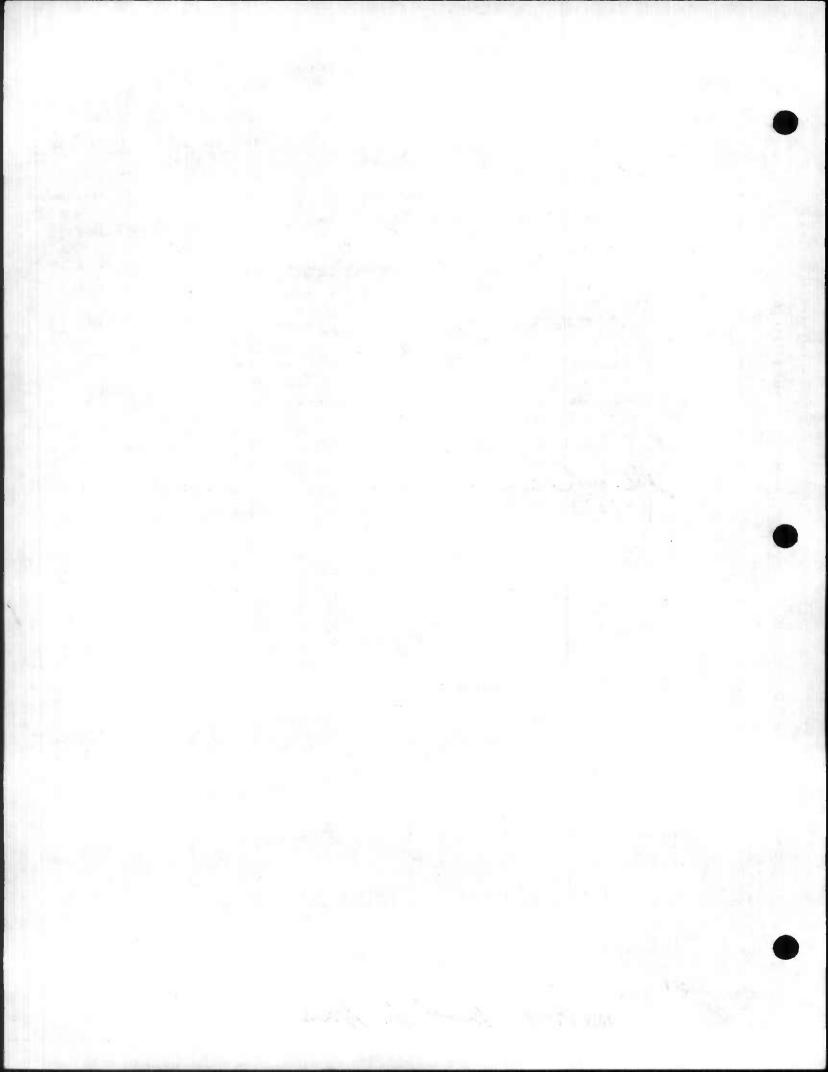


# Josephine Howard

	State of Maryland / Department of Health and Me  Certificate of Death	ental Hygiene 9	36055
		2. Date of Death	3. Time of Death
Physician /Medical	JOSEPHINE M. HOWARD		199 1:57 AM
Examiner  Funeral Director	4a Facility Name (II not institution, give street and number)  North Arund of Hospital  5. Social Security Number  236.76.0857  4b. City, Town, or Local Glen Bur  7. Age (In yrs. last birthday)  Wonths Days Hours Min.	tion of Death 4c. County of Anne	Death  Arundel  Birthplace (State or Foreign Country)
pu s	Usuel Residence of Decedent  10e. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
deryla f aho	MD ANNE ARUNDEL GLEN BURNIE		1 ☐ Yes <del>%</del> ₩ No
vith the Me t or 28a-f a be notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen of Wha	
h with	709 BERRY ROAD 21061	USA	
21215-0020 d within 72 hours after deeth with the Meryland giena. Then 'natural', or terms 23a or 28a-f show the Medical Examinar must be notified at completed by Funeral Director	11. Merital Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 Never Married 2 XX arried  1 Yes, Sive  1 Ves Decedent Ever in U,S. Armed Forces?  1 Yes, Sive  1 Yes, Sive  1 Yes 2 XX No Specify:  1 Yes 2 XX No Specify:	fy Yes or No- can, etc.)  14. Race- Black,  Specify:	American Indian, White, etc. WHITE
15-002 72 hours "natural", adical Ex-	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Busin	ness/Industry
od within 72 horygiene. For then "natural, my walfield	Elementery/Secondery (0-12) College (1-4or 5+)  11  College (1-4or 5+)  HOMEMAKER	OWN H	TME
d 2 Hilled v Hygie Ather t		First, Middle, Maiden Sumame)	TME
Maryland d 2 should be file th end Mental Hy 7 is marked oth traumatic event	JESSE MONTGOMERY HILDA MON		
S should end Men marke	19a. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural I	Route Number, City or Town, St.	nte, Zip Code)
1 end 2 Health em 27 is	PAUL D. HOWARD - HUSBAND 709 BERRY ROAD GLEN BUR	RNIE, MD 21061	
Peges nent of ant: If it	4 Donation 5 Other (Special)	Date 20c. Location - Cit 1/15 Glen Bur	nie, MD
Baltimopemit. Peg pemit. Peg pemit. Peg pepartment important: any injury o pncs.	KELLY GREGORY FINK 426 CRAIN HWY., SW.,		
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shoot, or heart failure. List only one cause on each line.	respiratory errest,	Approximete Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition e. Chronic Renal Failure resulting in deeth)		Onset and Death
	Due to (or as a consequence of):	D	V
oxecuted in and in-transit	Sequentially list conditions.  Due to (or es a consequence of):	p-/12	160
8760, Cete be executed hysiclen and the burial-transit dical Examin	if any, leading to immediate cause. Enter Underlying Cause, Disease or Injury c.		
requires that the death certificete be executed requires that the death certificete be executed reen signed by the ettending physicien and hould be detached for use as the burial-transit eted by Physician/Medical Exami	Due to (or as e consequence of):  d		
death death of for ed for sicis	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contri	bute to the cause of death?
P.O. dat the dat the etache		1 Yes 2 No 3	☐ Probably 4☐ Unknown
The law requires the rate has been signed page 2 should be d		24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause
Rec law has by ya 2 s			of death?
= F # 8 0	OF West and resident to resident	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical examiner?  1   Yes 2   No   No   Hospital: 150 Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home	Check only one)  9 5 Residence 6 Other	(Snecity)
O £ E E	27. Menner of Death 28a. Dete of Injury 28b. Time of 28c. Injury et 28	d. Describe how injury occurred	
Division C To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: Affer t completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined elemined	if. Location (Street and Number City or Town, State)	or Rural Route Number,
Cert Cert	4 ☐ Homicide building, etc. (Specify)		
Hospi 24 hou Funer stely fill	29a. Certifier (Check only one)  [X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred and manner stated.		
To the within To the comple	29b. Signature and title of certifier 29c. License number	29d. Date signed (	Month, Day, Year)
6	Datah marae 20 H0053939	11/12/90	1
n	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
State Registrar			
DHMH 16 Rev 6/95	NOV 1 7 1999 Beneva B spacks		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95



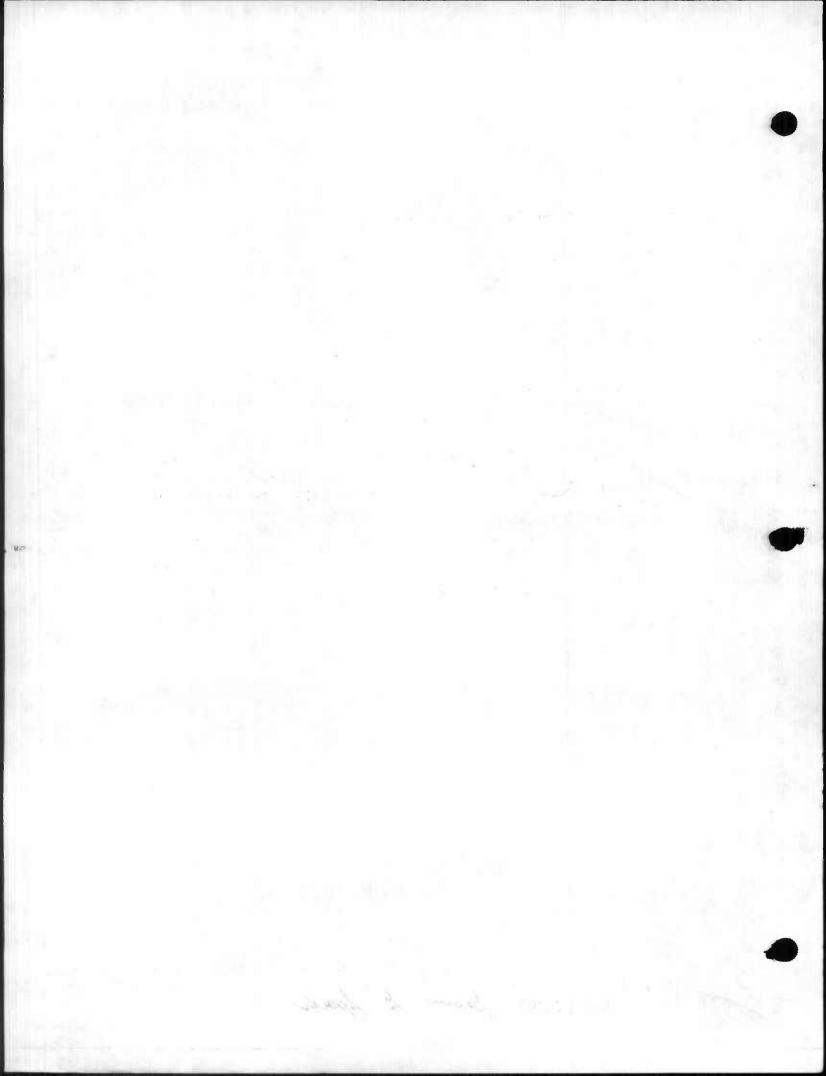
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** DAVID A. HORKY NOVEMBER 13, 1999 0730 /Medical 4a Fecility Name (# not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1310 GATWICK ROAD GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 15XM 20 F 46 MARYLAND Yrs. 220.56.8918 Director Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits - how the Medical Examiner must be notified at 1 ☐ Yes 2 No MD ANNE ARUNDEL GLEN BURNIE Funeral Director 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23a or 1310 GATWICK ROAD 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whife, etc. filed within 72 hours aftar Yes ANO 1 Never Married 2 Married 21215-0020 6 1 ☐ Yes XX No Specify: Specify: WHITE þ Widowed 4 □ Divorced "naturel" Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) SUPERVISOR SARGENT BUILDERS permit. Pagas 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If New Z7 Is marked other
any Injury or other terrested other. Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES W. HORKY, SR. HELEN ANTHONY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) THERESA ARNOLD 450 Glenmar Road B-4, Glen Burnie, MD 21061 altimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burlal 2 XX remetion 3 ☐ Removel from State Metro Crematory 11/15 Baltimore, MD 5 ☐ Other (Spe 4 Donation 22. Name and Address of Facility Fink Funeral Home, PA of Foneral Service Sugous 426 Crain Hwy., SW., Glen Burnie, MD 21061 Kelly Gregory Fink 23a. Par 1. Enfer the dispase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Extensive /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner Attending Physicien: The law requires that the death cartificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Records, P.O. Box 68760 physician Physician/Medicai tha Due to (or as e consequence of): usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown ata has been signed paga 2 should be da þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Tes 2000 1 ☐ Yes 2 ☐ No certificata Division of Vital funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home edicai Certification: To 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3D DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Netural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At complately filled in by the fu 1 Yes 2 No daath. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -> 1108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 2 222 32. Register's Sign State

**DHMH 16 Rev 6/95** 

Registrar



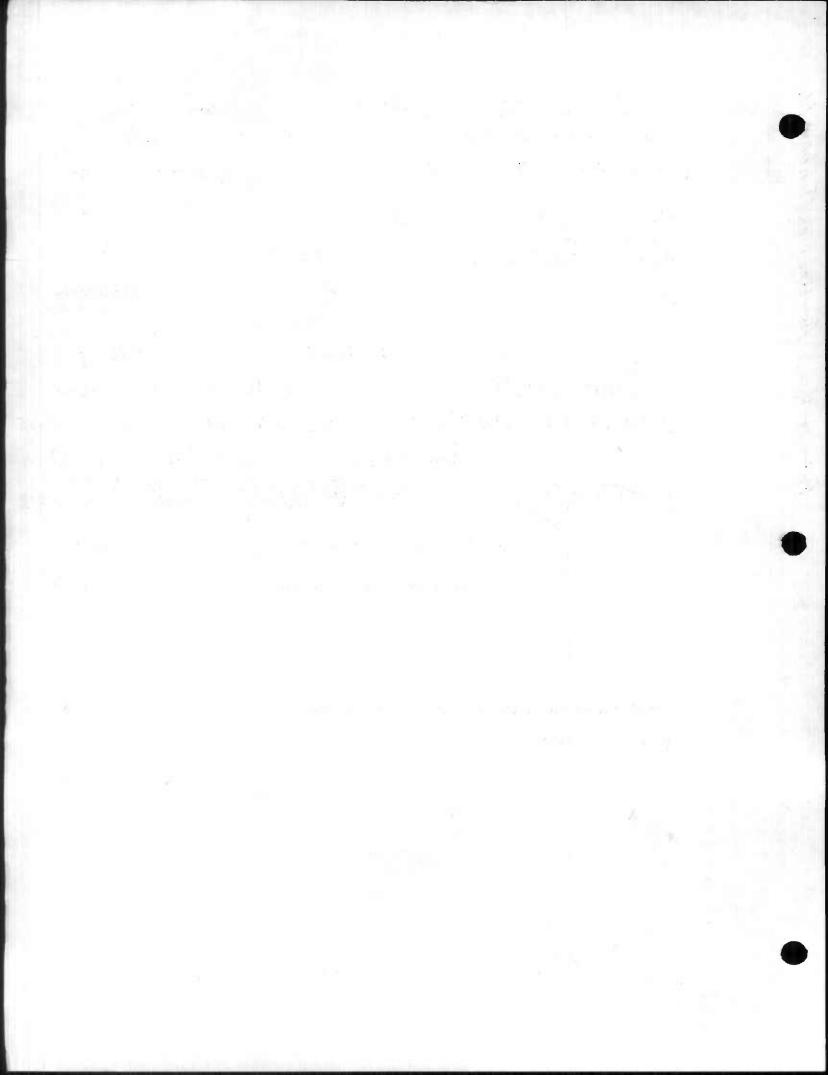
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Physician nnue November 15, 1999 1823 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Strent Known As: HAWKINS, Johnny Sinai Hospital of Baltimore Baltimore 7. Age (In yrs. last birthday) 2 Yrs. 8. Date of Birth (Month, Day, Year) July 16, 1917 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** -14-2389 1 M 200 F Months Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show BALTIMORE 1 M Yes 2 □ No Funeral Director 28a-f 10e. Street and Number 10g. Citizen of What Country? ö other traumatic event, the Medical Examiner must be 230 items! 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married 0 1 ☐ Yes 2☐M6 Specify Completed by 3 Widowed 4 □ Divorced 'natural', Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Labore Ld other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be is marked of 10 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Balto, MO 2/2/5 Department of Haalth Important: If item 27 20a. Method of Disp Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 4 ☐ Donetion 5 ☐ Other (Specify) eny injury 21. Signature of Funeral Service Licensee MO 2121 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Physician /Medical Acute Myocardial Infarction Sudden Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of). Physiclan/Medical Examiner Arteriosclerotic Heart Disease 10 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) P.O. Box 68760. The law requires that the death certificate be that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Carcinoma of Lung, Chronic Renal Insufficiency, 1 ☐ Yes 2 ☐ No 3 Probably 4 XUnknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? Diabetes Mellitus certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Aftar this certifics complately filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Naturel 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 295. Signatury and title of ce, 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Wood holm, Medicil Bly, 1835 ween Green tree Rof. 31. Date filed (Month, Day, Year) 32. Registra s Signature

State

Registrar DHMH 16 Rev 6/95

NOV

1999



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Edgar 4a Facility Name (If not institution, give street and number) Hankin 11:30 am November 13, 1999 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore City N/A sinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) SEP .18, 1919 6. Sex. 1 → M 2 □ F Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 214-18-3556 80 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No ILL LAKE BARRINGTON 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 20856 SWANSWAY DRIVE 60010 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 Do If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married WWII 1 Yes 2X No Specify: WHITE Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) MASTER PLUMBER PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) SIMON HANKIN FRANK 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) ROGER HANKIN / SON 20856 SWANSWAY DRIVE - BARRINGTON, ILL 60010 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State BETH EL MEMORIAL PARK 11/15/99 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur o of Funeral Se 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIR By comparations that coused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, that drive one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximete Interval Between Onset end Death Immediate Cause (Final Pneumonia 2 weeks disease or condition resulting in death) Due to (or as e consequence of): Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed?

**Physician** /Medical Examiner

attending physician and for use as the buriel-transit

certificate

Be

Certification: To

edical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Box 68760.

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ahow.

'natural', or harms 23s or 28s-f

Hygiene.

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy.
Importants if New 27 is marked other any Injury or other ver

filed within 72 hours after

altimore, Maryland 21215-0020

Director

Funeral

þ

Completed

88

2

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Glioblastoma

28d. Describe how injury occurred

26. Place of Death (Check only ona)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death 1 Natural
2 Accident

28a. Data of tnjury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Hospital: 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29c. License number

29b. Signeture and title of certifier Naren Babitt, M.D.

RES ODO

MOVEMber 13, 1999

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

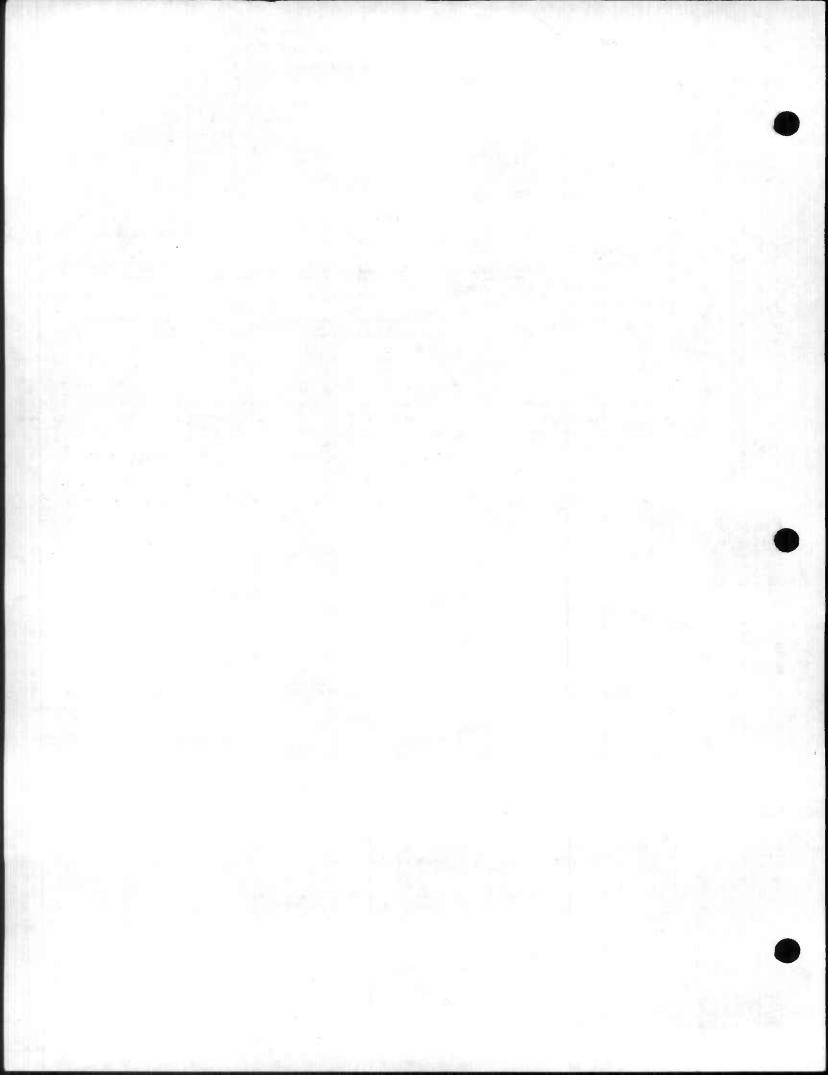
2401 W. Belvedere Avenue, Baltimore, MD 21215 Babitt 31. Date filed (Month, Day, Year)

State Registrar



**DHMH 16 Rev 6/95** 

10



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death NOVEMBER 7, 1999 **Physician** MARION HARRIS 4:19 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Yaar If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) FEB.15,1938 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months 1 M 2 F Days Hours 219-26-7567 GERMANY **Usual Residence of Decedent** 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4742 BYRON ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, 11 Marital Status Black, Whita, atc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ₺ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY SOCIAL WORK 17 Father's Nama (First Middle Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 80 LEVY SIMON LEWIN VIOLET 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 1404 BELLONA AVENUE - LUTHERVILLE, MD 21093 STEVEN HARRIS / SON 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stata BETH TFILOH CEMETERY 11/9/99 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Entar the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory errest shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immedieta Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown λq Completed 24b. Wara autopsy findings aveilable prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Wes case refarred to medical 8 28. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas 2 No Hospice 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 Yas 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et tha time, date and place, end due to the ceusa(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to tha cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and tifle of pertifier 29c. License number 29d. Data signed (Month, Day, Year) November 8 1999 025205 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) A.Riley 6-Bine M. Charles St. Bulto, md 2120x 6781

that

To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by the

**Funeral** 

Director

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28a-f

munt be n

altimore, Maryland

Marion

Pages 1 and 2 should be nent of Health and Mental

Department of Important: If any Injury or angles.

**Physician** /Medical

Examiner

hysician and the burlai-transit

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and

50

Box 68760,

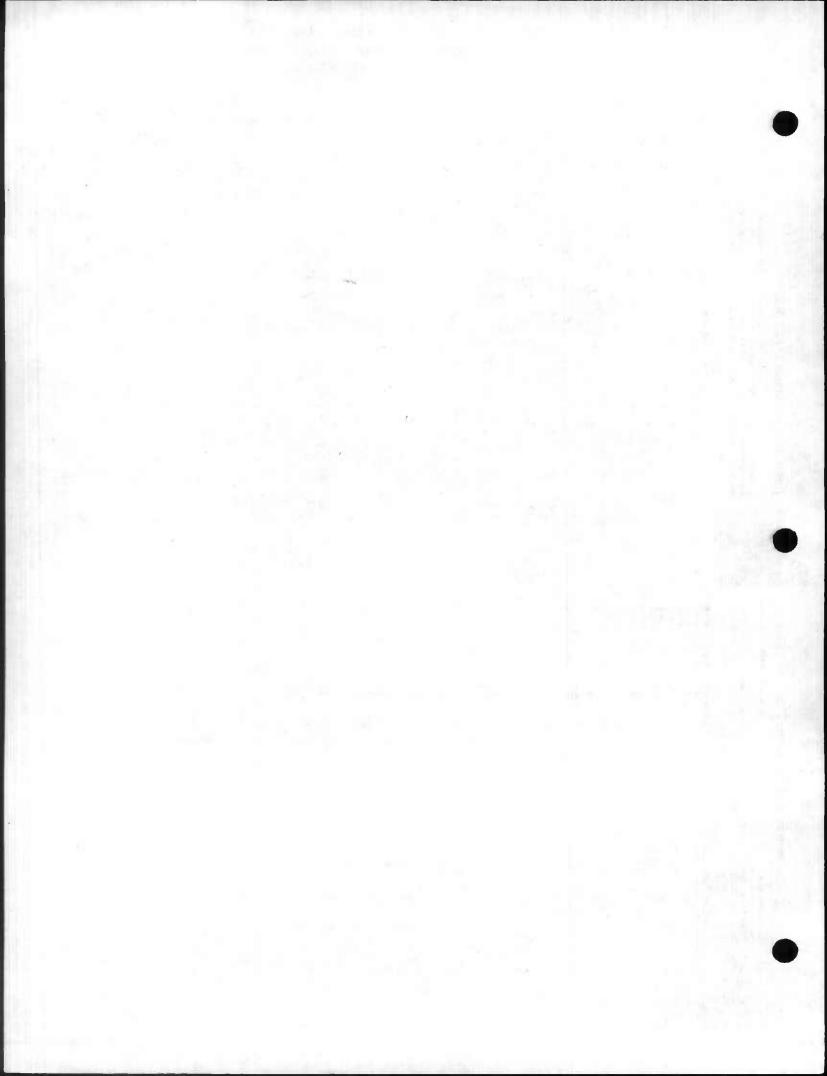
P.O. P

Records,

Division of Vitai

31. Data filed (Month, Day, Year) State NOV 16 1999 Registrar

32. Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death HAYWOOD Month 6:45 a.m. orine 12 November 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Barrington umber Beex Baltimore If Under 24 Hrs. 8. Date of 000 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Yrs. If Under 1 Year Birthplace (State or Foreign Country) S. C. Months Days 10 M 20 F Hours 216-28-2928 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? Barringt USA 21215 Kd on 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 ☑ No specity: Black Specify 3 Widowed 4 □ Divorced Yeer or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ntary/Secondary (0-12) 9th Grade College (1-4or 5+) Stella Maris - Hospice House Keeper 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Wash )avio Lee Dinale Annie 19e. Informent's Neme/Reletionship (Type, Print) Daugh +er 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ruth J. Hill Randallstown, MO. 21133 Lane 20a. Method of Disposition Date 20c. Location - City or Town, State 1€ Burial 2 Cremetion 3 Removel from Stete Nov. 18 Baltimore Park 4 ☐ Donetion 5 ☐ Other (Specify) Memorial 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Nutter Funeral Homes, Inc. 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. PKWY Balto, mo. 21216 Approximete Intervel Batween Onset end Death PULMONAR Immediate Cause (Fine disease or condition rasulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequance of): that initiated events resulting in death) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Wara autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 Also 26. Place of Death (Check only ona) Other: 4 Nursing Home 1 Inpatient 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA 28d Describe how injury occurred 27. Magher of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

The law requires that the death certificate be exec Box 68760. 2 signed by the atte Division of Vital Records, P.O. After this certificate funeral

Physiclan/Medical Examiner Be Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Certification: To filled in by edical

Physician

/Medical

Examiner

**Funeral** 

Director

or items 23s or 28s-f show

event, the Medical Examiner must be notified at

Be Completed by Funeral Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If I fem 27 is marked other than "natural". or in any injury or other traumatic events.

**Physician** 

/Medical

Examiner

State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Day, Year) NOV17

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature ang/title of beriffic

6 ☐ Could not be

istrar's Signature 1999

30. Name and address of person who completed dause of daath (Item 23a) (Type, Print)

FATRMOUNI

1.5 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and menner as stated.

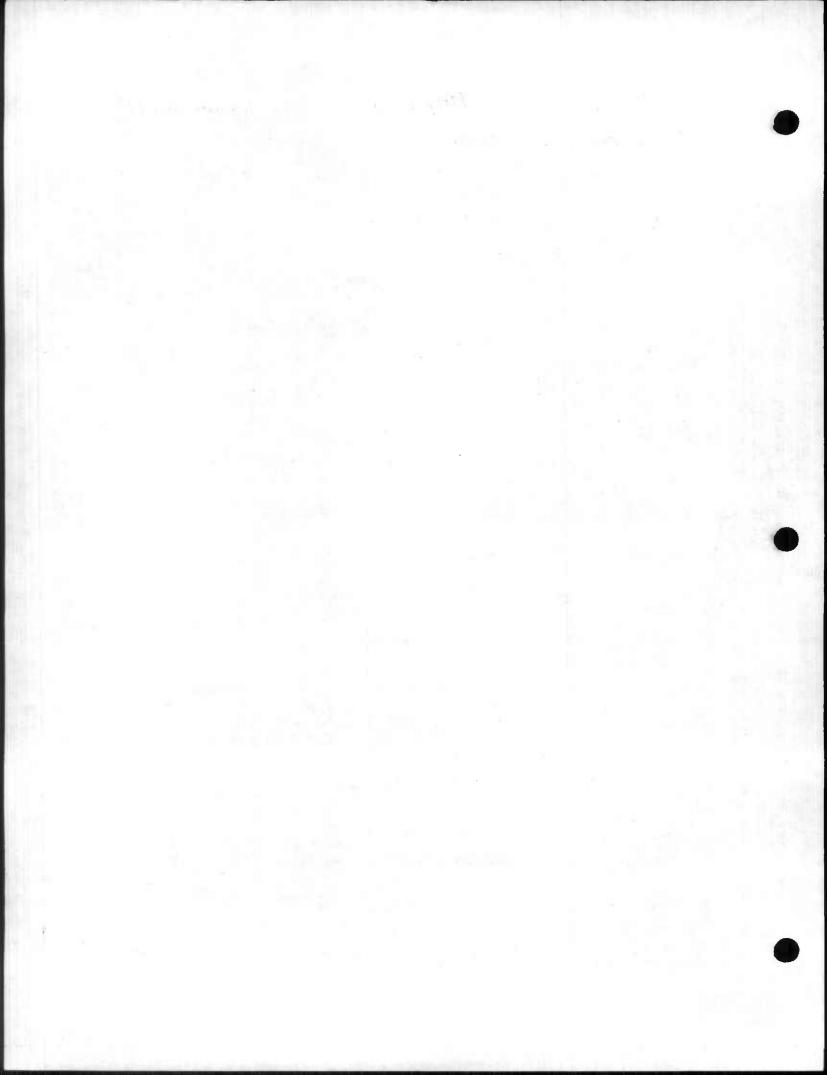
2. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner/stated.

29c. License number

AUE

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

**ORIGINAL** 



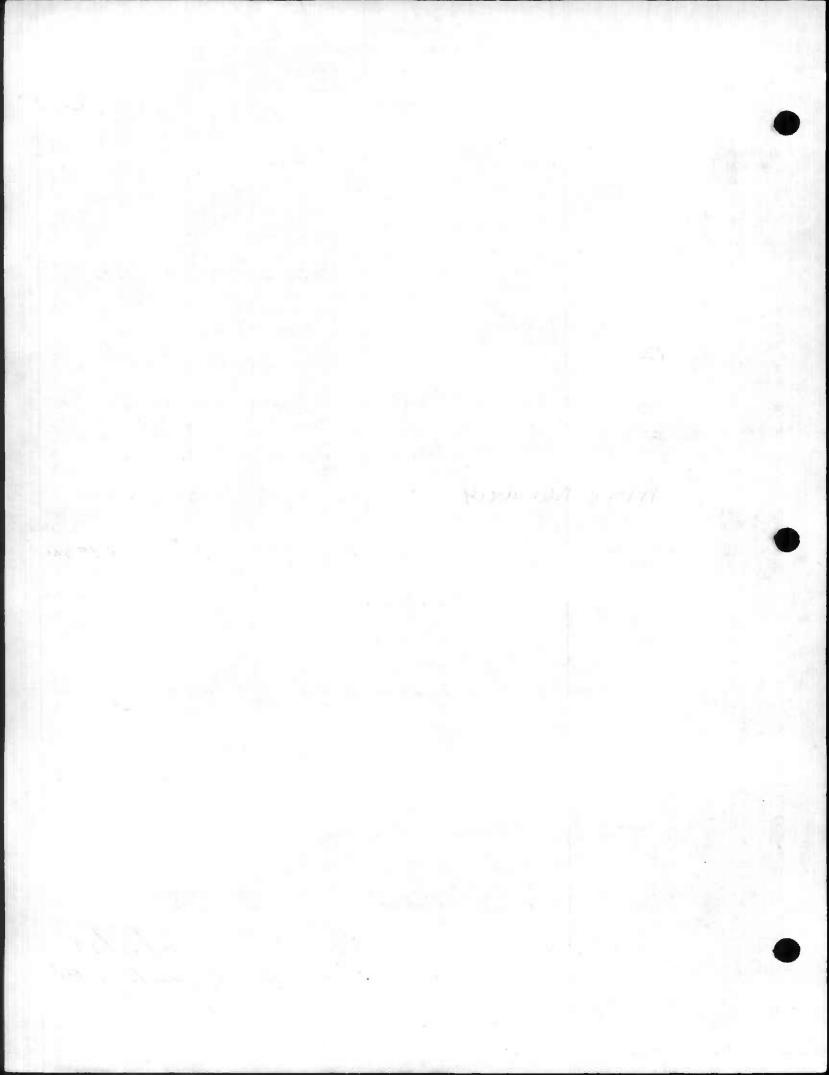
State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Physician November 11,1999 6:05 P Haynie Oscar /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c County of Deeth Examiner FutureCare-Cherrywood Reisterstown Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign FEB. 28, 1923 | Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** XXX 2□ F Director 225-20-9551 76 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c City Town or Location ment be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Carroll Manchester 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21102 U.S.A. items 23a 3260 Maple Avenue, PoBox 654 12. Was Decedent Ever in U,S. Armed Forces? 1 (☑ Yes 2 □ No If Yes, Give Yaar or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mentel Hygiena. Important: If Itam 27 is marked other than "naturel", or item eny injury or other treumatic event, its Medical Examina-Black, Whita, etc. 1 Never Married Married
3 Widowed 4 Divorced Specify: White Baltimore. Maryland 21215-0020 1 Yes 2 No Specify: þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ERNST HAYNIE GENOVA (unk.) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 3260 Maple Ave., P.O. box 654, Manchester, MD. Patricia Haynie (wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Nov. 16 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility to. Narshalf 736 Edmondson Ave. Catonsville, MD. 21228 Sterling-Ashton-Schwab Funeral, Home, 21228 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset end Daath **Physician** Obstructive Palmony Diserse Chionic /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physicien end the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yas 2 No Division of Vital 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 his 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Netural or Attending 5 Pending investigation n 24 hours efter deeth.

He Funeral Director: Aft
Dietaly filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fl (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 032882 Hord J. Mon 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) d cause of death (Item 23e) (Type, Print)
114 Business Cents DI. Reis Feifown, Mil

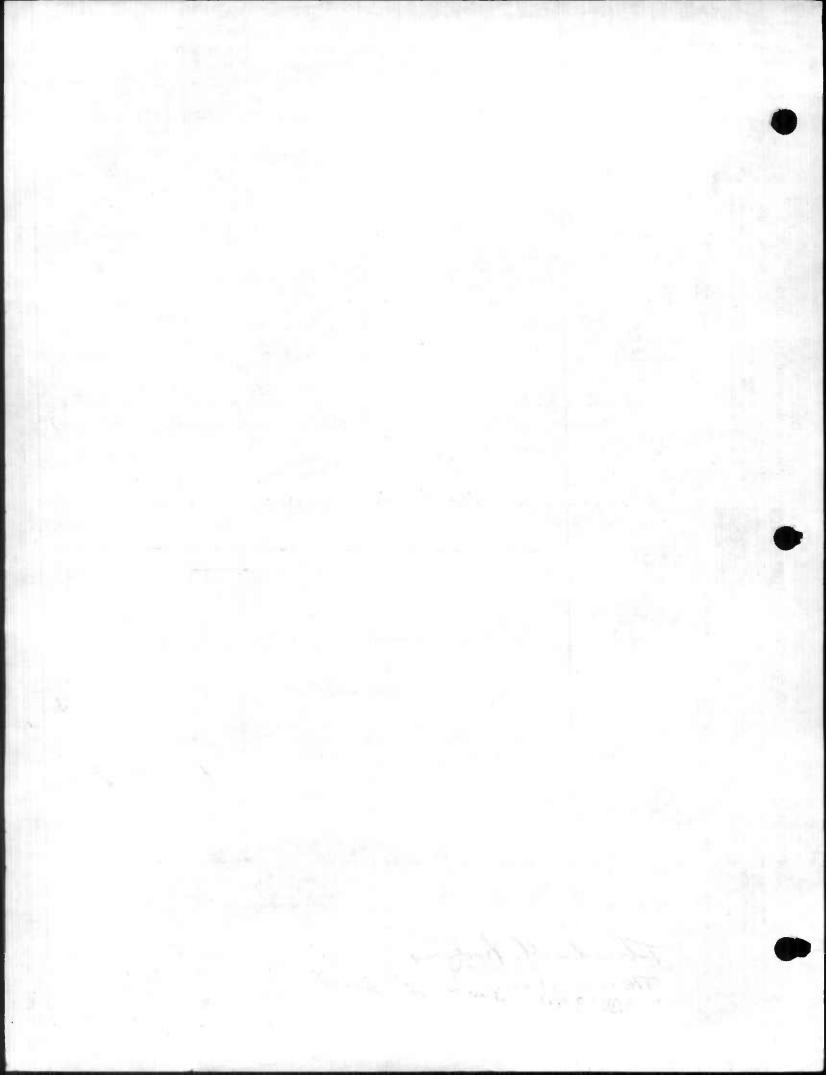
State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 1999 ▶ NOV 17



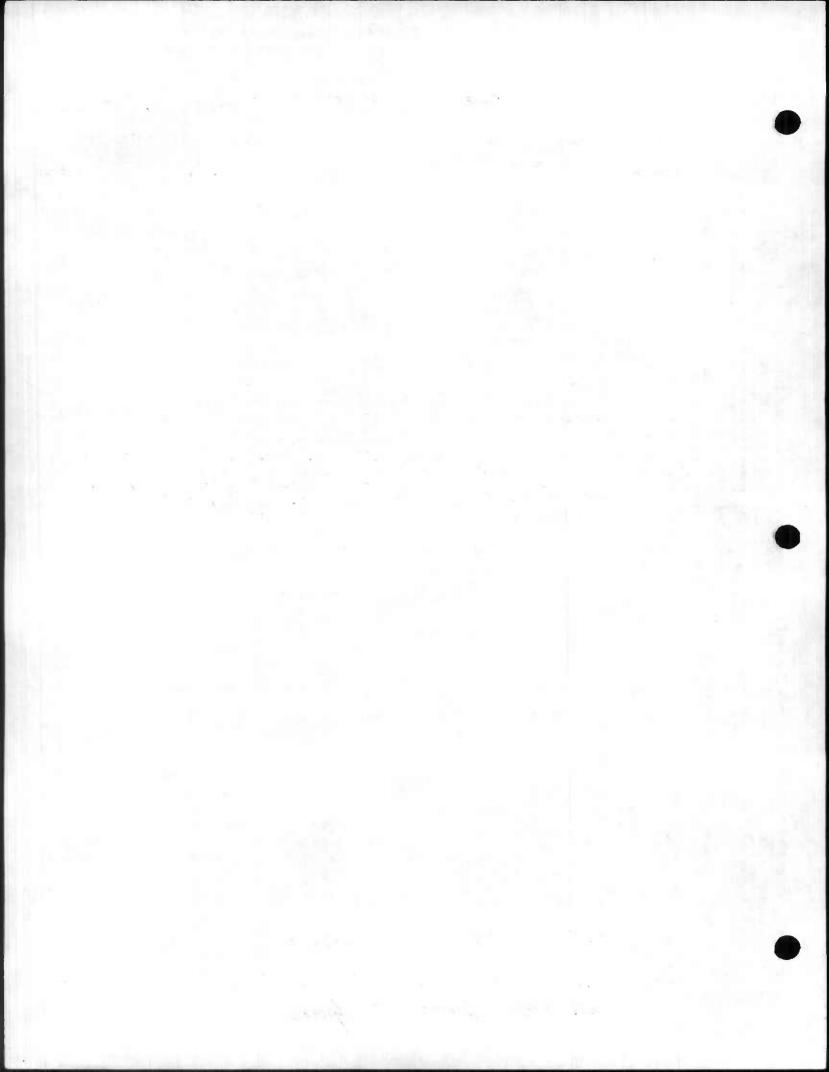


Physici	an	TEMS: #23 PART  1. Decedant's Nema (First, Middla, Las			Dealli	2. Data of Death Month Day	Year	3. Tima of Death 1207 PM
/Medio Examir	eal ier	4e Facility Nema (If not institution, give ECONO LODGE MOTE	TNGRA e street and number) L	m	4b. City, Town, or Lo		1, 1999 County of Death BALTIMOR	
Funeral Director		213-00-1011	ex 7. Aga (In yrs. 1	last birthday) If Under 1 Year Months Deys	_	8. Data of Birth (Month Day, Year)	9. Birth	placa (Stata or Forei
the Maryland 28a-f show notified at		Usual Rasidance of Decedant  10a. State 10b. County  M. A.	10c. City	y, Town or Location				10d. Inside City Limi
urs aftar death with	ral Di	10e. Street and Number  5/12 Pembord  11. Maritel Status	92 AV2 12. Was Decedent Evar in U, Armed Forcas?	10f. Zip Code 2 / 2 S. 13. Was Decedent of If Yes specify Cut	/ S Hispanic Origin? (Spe	cify Yas or No-	zen of What Cou	ican Indian,
	by	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ② Odo If Yas, Giva Yeer or Datas:	1 □ Yas 2 □ 10	Specify:		Specify: B	1Ac/c
9 1 3	Be Completed	15. Decedant's Ed (Specify only highest grad Elamantary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work dona liffa. DO NOT use retire	during most of working of Stacker	Sey:		Lane Ma
s 1 and 2 should be filed with f Haelth and Mental Hygiena, tem 27 is marked other ther other treumatic event, the	2	KUBET N. I 19a. Informant's Name/Ralationship (7 MALIJA Brooker		19b. Mailing Addrass (Stree 5/12 Pem	MATILDE and Number or Flura	1 Brook I Route Number, City of Alle, Bolli	Town, Stata, Zi	d. 2121
permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		20a. Mathod of Disposition  20a. Mathod of Disposition  21a. Cramation 3   4 Donation 5 Other (Specify  21. Signatura of Funeral Service Licenty	Removal from Stata N	tace of Disposition (Nama of ematary, cramatory or other ple to Zion Ce 22. Nama and Addr.	metery !! ass of Facility Be CAcoline	1/16/99 Be Hs Furecal St. Baltin	Himbre Home ore, M	J. 2121
Physician /Medical Examiner	Je.	23a. Part 1. Entar tha disaase, or compensor, or haart failura. List only over the compensor of the compenso	CULAR DILATATI NARCOTIC I HYPERTROPHY	COTIC INTOXICATION  T as a consequence of):	ATION COMP	LICATING RI ATING GON- DISEASE	GESTIV	Approximata Intarval Between Onset and Death
tificate be asscuted of physician and as the bunal-transit	Examiner	Sequentially list conditions, if any, taading to immediate causa. Entar Undarrying Cause (Disaase or injury that initialed events	c	r es e consequence of): as e consequenca of):				
cermicata be axecura nding physician and usa as the burial-tran	n/Medica	rasulting in death) Last	d					
mar ma daam cermicata be axecuted ed by the attending physician and detsched for use as the bunal-transit	y Physician/Medical	Part II. Other significant conditions co	d	ulting in the underlying cause gi	iven in Part I.		use contribute	N
as been sign 2 should be	by Phys	rasulting in death) Last	d	ulting in tha underlying causa gi	iven in Part I.		No 3 Pro	to the cause of de obably 4 Vinks Vare autopsy findin valiable prior to ompletion of cause f death?
ate has been signings 2 should be	Be Completed	Part II. Other significant conditions co	Hospital:		26. Placa of Death	1 Yes 2	No 3 Pro	Vare autopsy findin variable prior to ompletion of cause f death?
ing ringsreten. The law requires, that this cartificate has been sign uneral director, paga 2 should be	To Be Completed	Part II. Other significant conditions co	Hospital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA CO	26. Placa of Death ther: 4 Nursing Hor ury at 5/k? ] Yas 2 S No	24a. Was an autoperformed?  24a Was an autoperformed?  1	No 3 Property occurred  No 11  No 11  No 12  No 12  No 12  No 13  No 14  No 15  No 15  No 16  No 17  No 17	vare autopsy findir valiable prior to ompletion of cause to death?  SCENE  **Tal Route Number, LODGE**
asth. or: Aftar this cartificate has been sign the funeral director, paga 2 should be	Certification: To Be Completed	25. Was casa rafarred to medical axaminar?  1	Hospital: 1   Inpatient 2    28a. Data of Injury (Month. Day Year) Found: 11-1-99 28a. Place of Injury - At ho	ER/Outpatient 3 DOA CO 28b. Tima of P 28c. Injury WC 1 Doma, farm, street, factory, offica EL	26. Placa of Death ther: 4 Nursing Hor ury at ork?  ] Yas 2 No	24a. Was an autoperformed?  1	No 3 Property occurred  A Number or Ruin  A ECONO  KESVIL  and mannar as	obably 4 Junk  Vare autopsy findir valiable prior to ompletion of cause of death?  The 2□ No  ity) SCENE  Tal Route Number, LODGE LE, MD.  stated.



				State of Ma		/ Depar		Health and	Mental Hy	_	9 36063
	Physicia		1. Decedent's Name (First, Middle, Last)	Angelin	e		Ierise	2	2. Date of De Month	Dey ber 15,	3. Time of Deeth Year 1999 8:15 PM
20	/Medic		4a Facility Name (If not institution, give	street and number)				4b. City, Town, or			
7	LXamin	51	2506 Gray Manor	Terrace				Dung	lalk		altimore
	Funeral Director		5. Social Security Number 6. Sec	7. Age	(In yrs. last		If Under 1 Year Months Days	r If Under 24 Hrs	8. Date of Bir (Month, Da	th ay, Year)	9. Birthplece (State or Foreign Country) West Virginia
5-0020 72 hours efter deeth with the Maryland	fied at		Usual Residence of Decedent  10a. State 10b. County  Maryland B	altimore	10c. City, T	own or Loca	ition	Dundal	ς		10d. Inside City Limits 1 ☐ Yes 2 🗷 No
with the	a or 28e be notif	ᅙ	10e. Street and Number				10f. Zip Code	21.22		10g. Citizen of V	What Country?
£	23	흥	2506 Gray Manor T			42.34	- Decedent -4	2122			a - American Indien,
20	0 9	by Funeral	11. Marital Status  1 Never Married 2 Married  3 SWidowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2日N If Yes, Give Year or Dates:			es, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl Specify:	o Rican, etc.)	Bled	k, White, etc.
9 8	"netural", dical Ex		15. Decedent's Edu	16.55(0.456(0.1)	1 4	6a Deceder	nt's Usual Occu	metion		16h Kind of Bu	usiness/Industry
	nd Mentel Hygiene. marked other then "natur imatic event, tre Med cal	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 Years	College (1-4or 5-		(Give kir life. DC	nd of work done NOT use retin	e during most of wor ed)	rking		Home
	E E		17. Father's Name (First, Middle, Last)						ne (First, Middle	, Maiden Sumam	
and b	D D D	To Be	Frank Leon					N	ary Lou	ise Giov	<i>r</i> an
Maryiand	end Mentel ie marked o eumatic eve	Ĕ	19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailing	Address (Stree	et and Number or Ru	ral Route Numb	er. City or Town.	State, Zio Code)
00 01			Victoria Ritchie	(Daughte:				nor Terra			
	Department of resets and Mentel Hyglene. Important: if Nem 27 le marked other then any Injury or other treumatic event, tre Mance.	-	20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ R		20b. Place ceme	etery, crema	ion (Name of tory or other pla		Date		City or Town, State
ting the	Department of Important: If It any Injury or o		4 □ Donation 5 □ Other (Specify)		HIGH			lem. Gdns	11/18/	99 FOL	Lansbee, WV
Bait Permit.	mpor any Ir		21. Signature of Funeral Bervice Ligense	h/L	111		Name and Addi da-Ruck	ress of Fecility  Funeral	Home of	Dundalk	Tnc.
2,2	32.00		1 hall	10/20	1//			Ave. Du			
			23a. Parti. Enter the disease, or compli shock, or heart feilure. List only or	e cause on each lim		Do not enter	the mode of dy	ring, such as cardia	or respiratory a		Approximate Intervel Between
/ /M	ysician Medical aminer		Immediate Cause (Final disease or condition resulting in death)	arte	nisc	level	-c He	art D	sease		Onset and Death
2	*	luer	Due to (or as a consequence of):								
760,		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ľ	Oue to (or as	s a conseque	once of):				
	5.9	Physician/Medical	that initiated events resulting in death) Last		Oue to (or es	a conseque	nce of):				
m =	for	5	Dat II Other size (Feed and distance of	A-75- at A A A A A A A A A A A A A A A A A-	A A In/-	- 1- 1- 1 4		to a Dodd	ook Did	Achana was as	Adhirts to the course of death 2
P.O.	d by the		Part II. Other eignificant conditions con  Alz Kuimer		1	ig in the uno	enying cause g	IVen in Pen I.		Yes 207No	ntribute to the cause of death?  3 Probably 4 Unknown
Records, P		Completed by								an autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of death?
i Rec	ate hes pege 2								40	1000	100
	certificate rector, pe		OP 144						10		1 Yes 2 No
of Vitai	s certific director,	O Be	25. Was case referred to medical examiner?	lospital:			_ 0	ther	eth (Check only		
O E	5 7	⊢⊦	1 Yes 2 Q/No ''	1 LI Inpatier		/Outpatient lb. Time of	3LI DON	4 LI Nursing F		dence 6 Oth how injury occur	11.
C 2	the fune	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of trijun (Month, Day		Injury	M 1[	ury at ork? ☐ Yes 2 ☐ No			
- No. 2	rel Director: lied in by the		4 Homicide determined	28e. Place of Injubuilding, etc.	ry - At home . (Specify)	o, ferm, stree	t, factory, office		City or To	wn, State)	er or Rural Route Number,
the Hospital	To the Funeral Di		ane)		examination		stigation, in my	opinion, death occu		date end pteca,	end due to the ceuse(s)
P 5 4	Tot	Σ	29b. Signeture and title obcertifier	m. (0	127		29c. Licer	11150		29d. Date signe	d (Month, Day, Year)
(			30. New and address of person who co	mpleted cause of de		3a) (Type, Pri	S. EC	Lwood A	WE, B.	ALTO,1	/1999 MD 2124

State Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Dev **Physician** Month /Medical (It not institution, give street end number) 4c. County of D 4b. Sity, Town, or Location of Death Examiner if Under 24 Hrs. 8. Date of Birth Month, Day, If Linder 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 2 F 212 578 Director -50 Usuel Residence of Decedent 10a. Stete 10b. County 10d. Inside City Limits 10c. City, Town or Location show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified as 1 Yes 2 No **Funeral Director** mole 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number . Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 D No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien, 12. Black White one wer Merried 2 Merried 1 Yes 2 No Specify þ 3 Widowed 4 Divorced imericar Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retiged), 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) Pages 1 end 2 should be filled with nent of Health end Mental Hygiene. mt: If Nem 27 is marked other than 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eletionship (Type, Print) . or other Method of Disposition 20c, Location - City or Town, State 20b. Plece of Disposition (Name of Date 1 Buriel 2 Cremetion 3 ☐Removel trom Stete Department Important: I any injury o 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licansee ruemo 1 22a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) SOPHALTEAL Examiner Due to (or es a consequence of): Physician/Medical Examiner UMGE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of): been signed by the attending p should be detached for use as: 23b. Did tobacco use contribute to the cause of death? Pert IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? pege 2 1 Yes 2 No 1 Yes 20 No certificate 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year)

Box 68760. Records, P.O.

The law requires that the death certificate be executed Division of Vital or Attending Physician: After this funerel r death. filled in by

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

within 24 hours after deat To the Funeral Director: Hospital \$

State Registrar

29b. Signeture end title of certifie

29c. License number

1 Yes 2 No

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

E. MORTHERM PKWY, MAR BALTHAORE, MD 21214 3007 MD 31. Dete tiled (Month, Dey, Year)

NOV 17

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Diveture

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

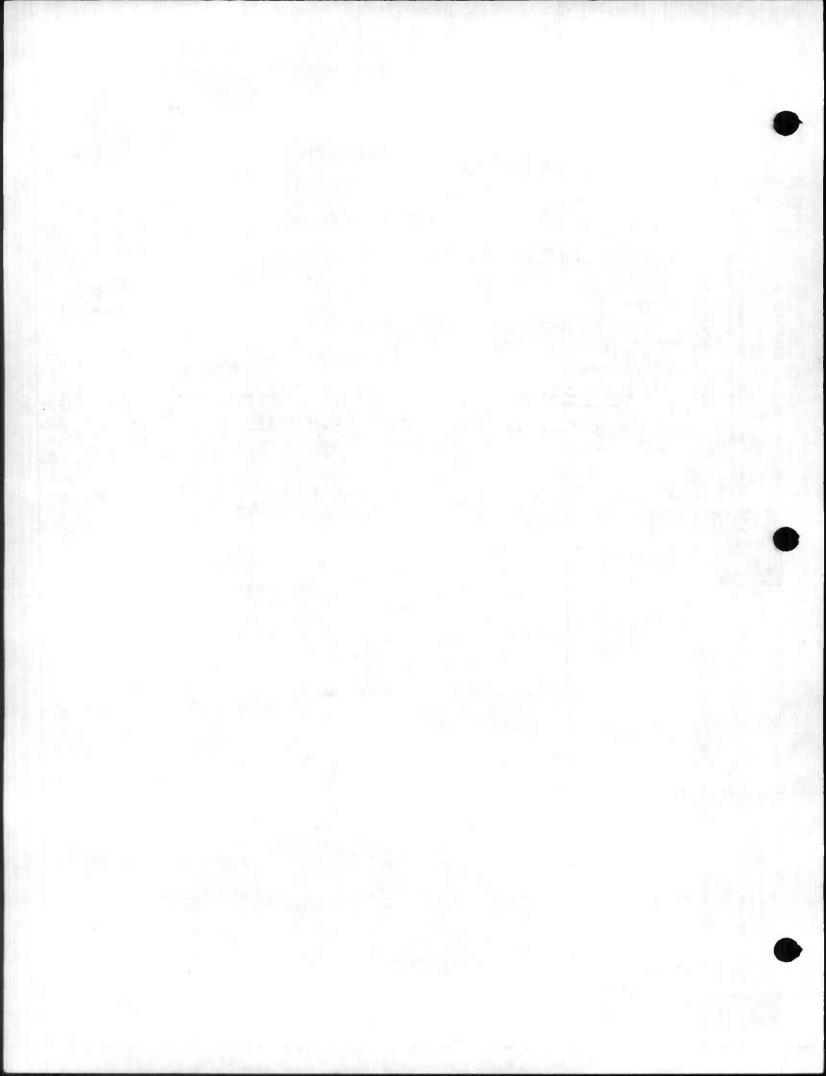
4 Homicide

(Check only one)

32. Registrar's Signeture

28b. Time of

28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify)



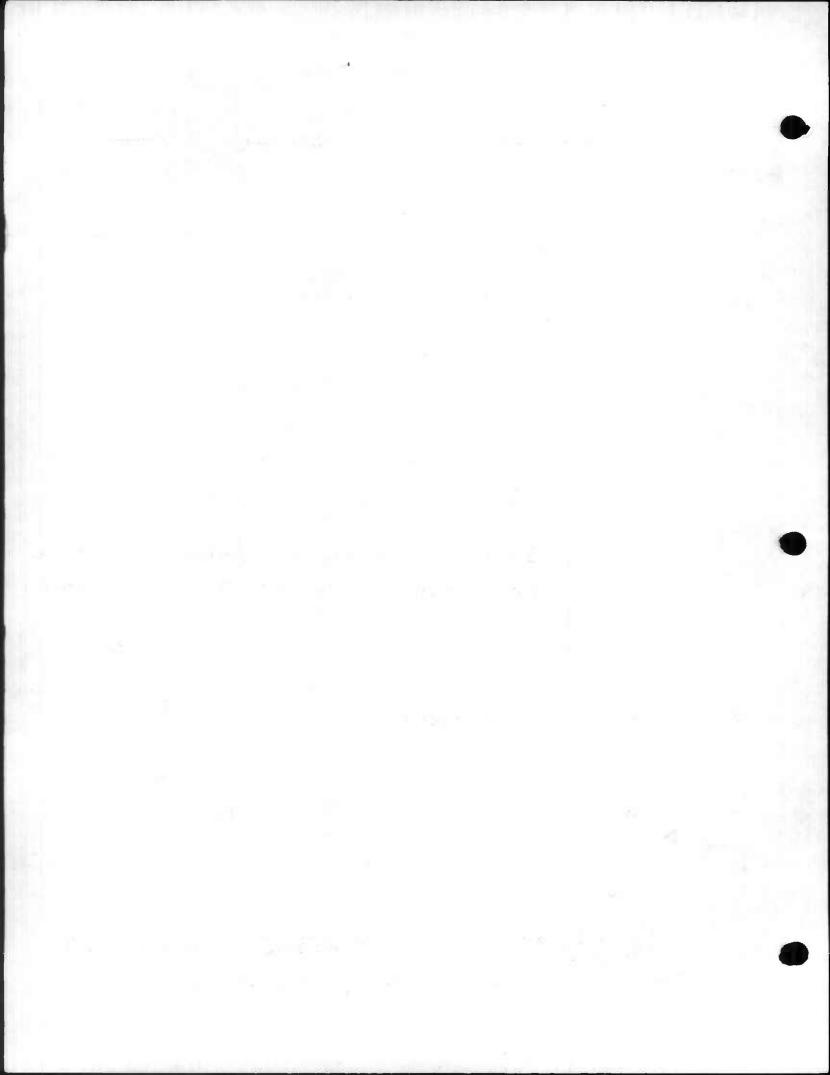
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month **Physician** Hazel James 0630 99 14 /Medical 4e. Fecitity Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Baltimer Wintton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F Months Deys Hours 213 18 7283 Usual Residence of Decedent Yrs. Director the Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits Injury or other traumatic event, the Medical Examiner must be notified at Balto Ma 1∭ Yes 2□ No Director 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? ō 1349 IN modon "natural", or itams 23a 21239 U.S. A Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ 10 If Yes, Give ✓ Year or Dates: 14. Race - American Indien, Black, White, etc. 11. Maritet Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiena. Important: If Item 27 Is marked other than "natural" or hemany Injury or other traumonts. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗷 No Blac Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) L-AUNdress 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) reld Mary ames 19e. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6580 P.ONEET CT Balto. mg 21214 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac curespiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physiclan /Medical Immediate Ceuse (Finat 5 months lowe extremity Wani disease or condition resulting in death) Examiner Physician/Medical Examiner Know burial-transit The law requires that the death certificate ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Due to (or es e consequence of) Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sorcopenia 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Was en eutopsy performed? 201 1 🗆 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Wes cese referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ tnpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

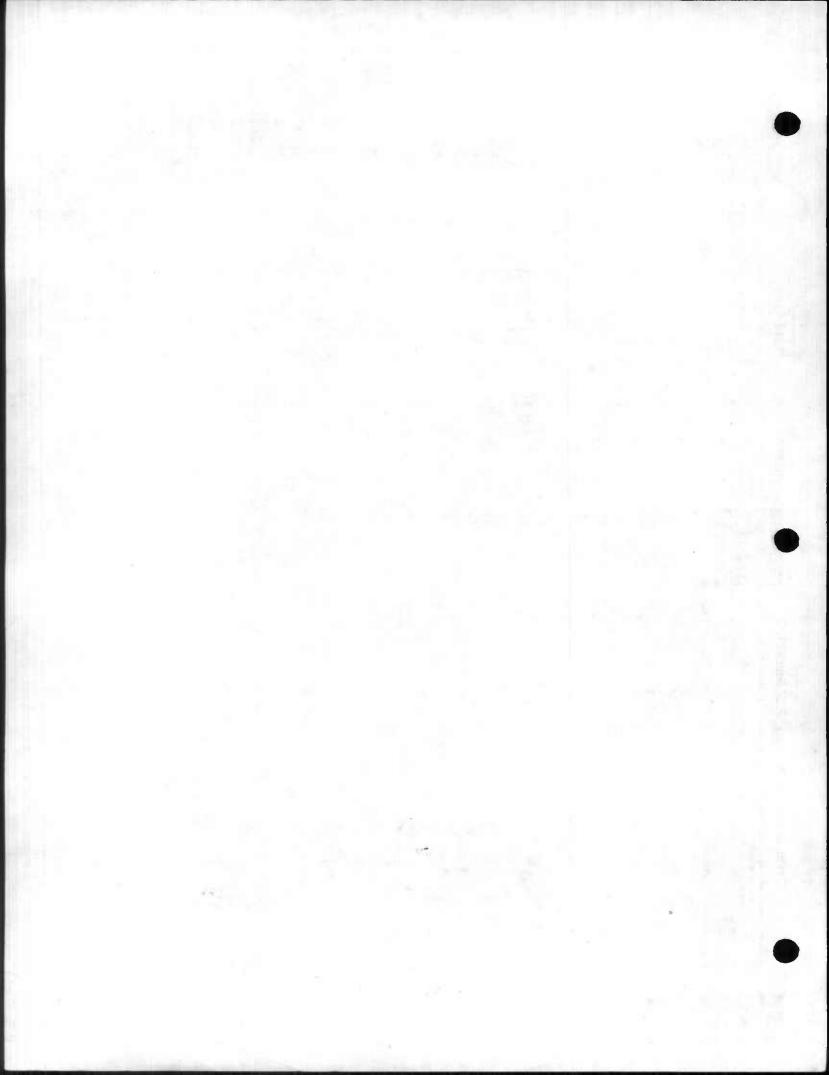
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dey, Year, W 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Partury, Bult, MD 21218 Jeff Landsman 106 €. Univ 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State parks Registrar NOV 17

**DHMH 16 Ray 6/95** 



State of Maryland / Department of Health and Mental Hygiene 99 36066

			Certific	ate of t	Jeath		Reg. No.		
Physician	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Yaar 12 'UC	1
/Medical	Jar byra Jennis 4a Facility Nama (If not institution, give	1		4	b. City. Town, or	Location of Death		999 12-95 Death	P
Examiner	University of Man	Sand Medical	System		12 11.	nore	N/	Δ	
Funeral	5. Social Security Number 6. Se	X 7. Age (In y	- Mont	der 1 Yaar hs Days	If Under 24 Hrs Hours Min		th v. Year)	Birthplace (State or Fore Country)	ign
Director	Usual Residence of Decedent	J 218 F	3 Yrs.			Jan. L	2,1926 V	Washington, D.	<u>C.</u>
Mand Mand	10a. Stata 10b. County	10c.	City, Town or Location					10d. Inside City Lim	its
Man and and and and and and and and and a	MD. Batti	more F	Randalls	town	)			1 □ Yas 2 □ N	No
ith the second	10e. Street and Number		10f.	Zip Code	2.7		10g. Citizan of WI	nat Country?	
e 23e	3807 Pikeswa		ALLS AS MOS DO	21	33	Paneits Van as Na	USA	- Amarican Indian.	
offer death with the Main refer as a 23a or 28a-f a niner must be notified Funeral Director	11. Merital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Evar in Armed Forces?			n, Mexican, Pua	Specify Yas or No to Rican, etc.)		Whita, atc.	
ours o	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Year or Datas:	1 ☐ Yes	s 2.2H%o	Specify:		Specify:	Black	
flied within 72 hours effer death with the Maryland Hyglene. Hyglene then "natural", or flema 23a or 28a-f ahow ent, the Medical Examinar must be northed at a Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	lication le completed)	16a. Decedent's U (Give kind of	suel Occupa work done	ation furing most of wo	orking	16b. Kind of Bus	inass/Industry	
withir then then the Man	Elementery/Secondary (0-12)	College (1-4or 5+)	School	Sec	4		Boltima	· City Public Sc	6
12 should be filled within 72 hours eft in end Mental Hygiene. The merked other than "natural", or treumetic event, the Medical Event To Be Completed by F	17. Father's Nama (First, Middle, Last)		10011001			ma (First, Middle,	Maiden Sumame		noo
should be marked or wmatic eve	Robert Mo	pore			Moze	lle As	h		
le and le mar	19a. Informent's Neme/Relationship (T)	ippe, Print) Husband	0.1.			_	er, City or Town, S		
1 and Health Health Health Wither th	20a. Method of Disposition		b. Place of Disposition (	Name of		. Kandalls Date	town Ma	d, 21133 City or Town, State	
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교투원증	21. Signature of Funeral Service Licens		22. Name	and Addras	1,1001		neral Ho	mesi Inc.	
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	23a. Parl 1. Entar tha disease, or composhock, or heart fellure. List only o	lications that daused the done cause on each line.	eath. Do not entar tha n	node of dying	g, such es cardia	c or respiretory a	rrest,	Approximete Intarvai Batween	
Physician								Onset and Death	
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ةِ السَّادِ		Elevales	o (or as a consequence	of):				1	
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		d							
The law requires that the death state has been signed by the attenpage 2 should be detached for u.	Part II. Other significant conditions co	ntributing to death but not	resulting in the underlyin	ng causa give	en in Part I.	23b. Did	tobacco use copt	ribute to the cause of dea	th?
d by the letach						10	Yes 2 No	3 Probably 4 Unknown	own
signe d be d						240 Was	an autonou	24b. Were autopsy linding	10
The law requirements cate has been suppage 2 should							en eutopsy rmed?	available prior to	•
or Attending Physician: The law requires the for deeth.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by						10	Yas 2 No	of death? 1 ☐ Yas 2 ☐ No	
entificate pector, pe	25. Was casa refarred in medical				26. Place of De	eth (Check only o		TE TAS ZE NO	
hysich his cer if direc	axaminer?	Hospital: 1 Inpatient 2	P☐ ER/Outpatient 3☐	DOA Othe	ne:		dence 6 Otha	(Specify)	
Ing Pt Mer th unara Ion:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Data of Injury (Month, Day Year		28c. Injury Work		28d. Describe	how injury occurre	d	
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injury - A	t homa, farm, street, lac		Yes 2□No	28f Location /	Street and Numbo	r or Rural Route Number,	
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hours merel ly fille	29a. Certifier 1 Certifying Phys	sician: To the best of my k	cnowledge, death occurr	red at the tim	e, date end plac	e, end dua to the	causa(s) end men	nar as steled.	
he Hospi in 24 hou he Funer pletely fil	(Check only ane) Medical Exami	ner: On the basis of axam and manner stated.	ination and/or invastigat	tion, in my or	oinion, daath occ	urred at the tima,	date and plece, a	nd due to tha cause(s)	
With To the	29b. Signature end title of certifier	2/1	Nattingly	29c. License	4		29d. Date signed	(Month, Day, Year)	
10	10/1/	1 m	"	PIZ	246		NOV-1	1777	
V /	30. Name and address of person who co		tern 23a) (Type, Print)	071	210				
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State of Maryland / Department of Health and Mental Hygiene

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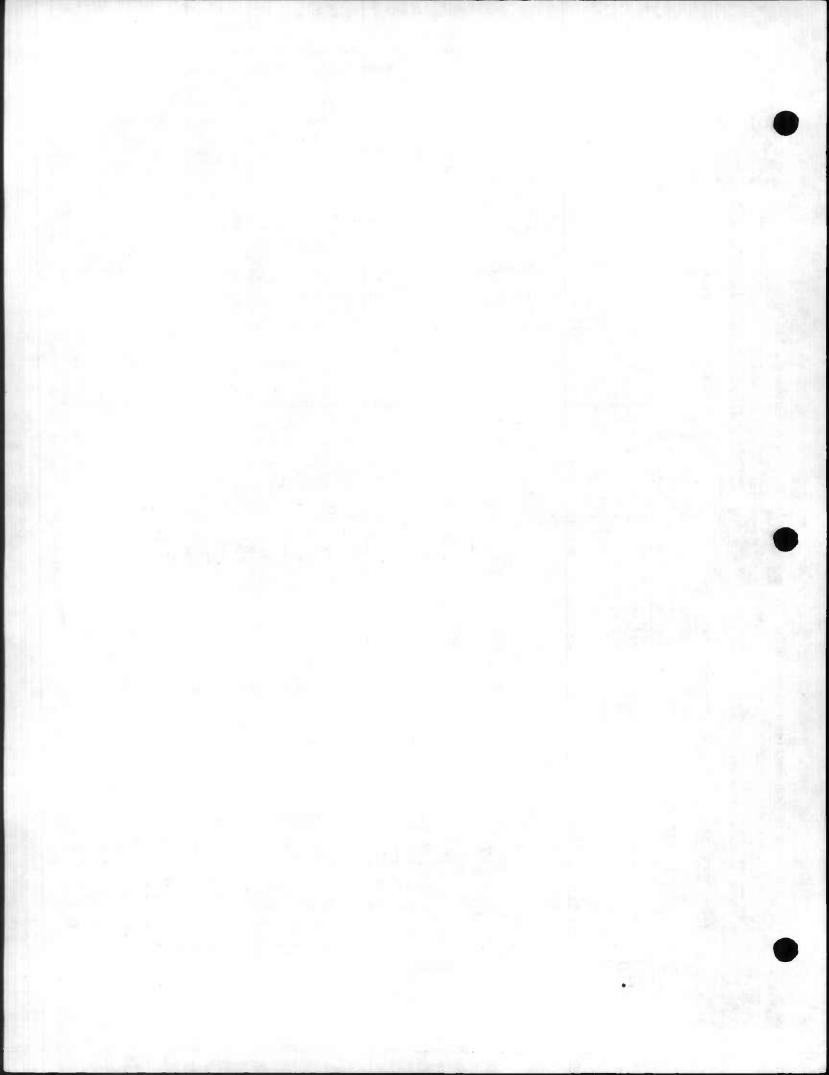
JDR	EY JOHN	SON	V			Ce	rtificate d	of Death		Reg. No.				
	Discontinuis		1. Decedent's Name (First, Middle, Las	t)					2. Dete of D Month		Veer	3. Time of Death		
	Physicia /Medic		AUDREY			JA	CKSON-	JOHNSON	Novem	ber 10,	1999	12:28 P.N		
	Examin		4a Fecility Name (If not institution, give				-		or Location of Dea	th 4c. Count	y of Death			
			222 South Washin	gton Stree	t			Baltim			N/A			
	Funeral Director		5. Social Security Number 6. Security Number 11 Usuel Residence of Decedent	9x 7. Age □ M 25√ F 4		Yrs.	Months Da		n. (Month, D	lay, Year)	9. Birthp Coun 9 MA	lace (Stete or Foreign itry) RYLAND		
	brat a	1	10a. State 10b. County		10c. City	Town or L	ocation				1	Od. Inside City Limits		
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020	h wit	0	2405 E. OLIVER	STREET			2	1213		U.S	. A .			
	72 hours after death with the Maryland *natural', or frems 23s or 28s-f show of sall Examine must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:		5. 13.	Wes Decedent If Yes, specify C	of Hispanic Origin? Cuban, Mexican, Puo No <i>Specify:</i>	(Specify Yes or Nerto Rican, etc.)	o- 14. Ra Bla AFR( Specif	ck, White,	etc.		
5	72 ho	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Oc	cupation	ndina	16b. Kind of B	usiness/Inc	dustry		
21215-0020	E	Completed	(Specify only highest grad Elementery/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use re	ne during most of w tired)	rorking	1.0				
	flied wi Hyglen ther th ent, the	Son		2YEARS			SECRET					1999 12:28 P. of Death N/A  9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits  1		
Maryland	H OCH	8	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	e, Maiden Sumai	ne)			
2	should nd Men marke	ဥ	WILLIAM L.					ANN	HIGHS					
a	2 should be made		19a. Informent's Name/Relationship (7		II.D.			eet end Number or				Code)		
	EENL	-	WILLIAM L. JAC	KSON/ FATI	_			ALAMEDA				0		
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ď	The law ata has page 2	E							A	Yes 2□No	D	Ves 2□ No		
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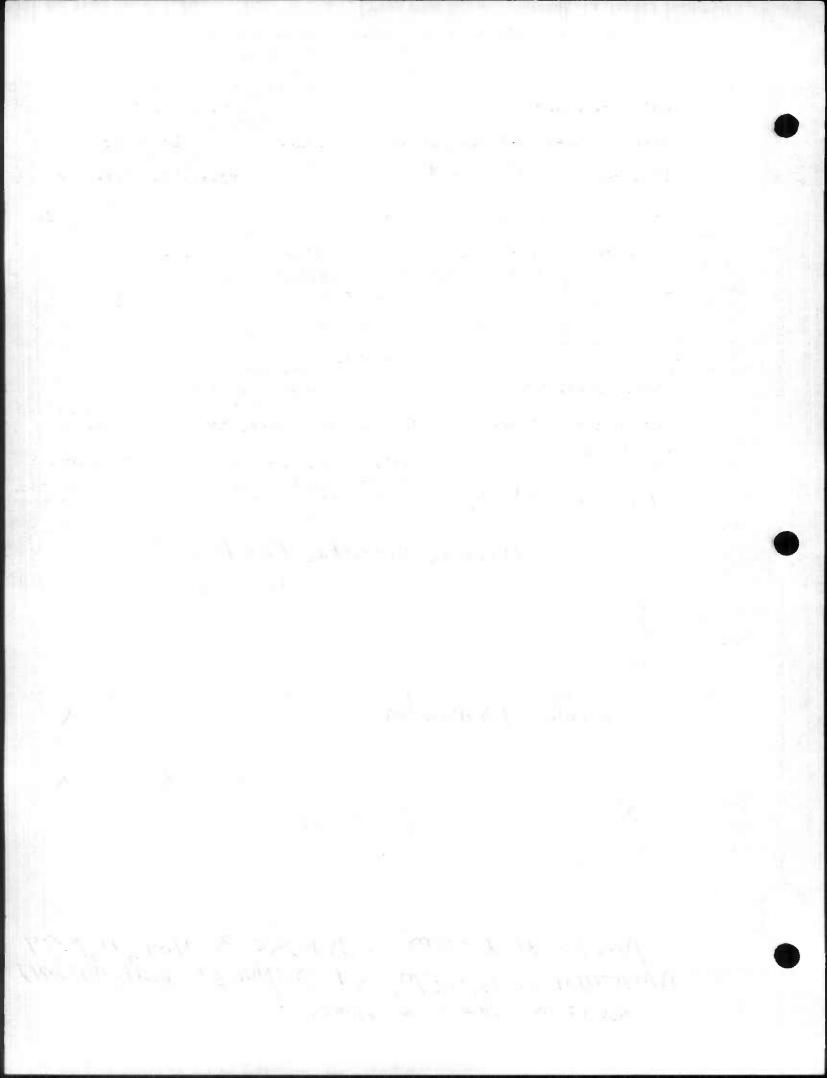
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician** Month Helen D. Jones 10, 1999 8:30 A.M Nov. /Medical 4a. Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Dulaney Valley Assisted Living Baldwin Baltimore 5. Sociel Security Number If Undar 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X 87 Director 216-03-0461 Aug. 1, 1912 Virginia Usuei Rasidance of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturest, or Items 28a or 28a-f show any Injury or other traumetic event, the Marical Examiner must be notified as 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Baldwin 1 ☐ Yes 2)☐XVo 10e, Streat and Number 10f. Zip Coda 10g. Citizan of What Country? 5001 Carroll Manor Road 21013 U.S.A. Funerai 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarlcen Indian, Bieck, Whita, atc. 1 Nevar Merried 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ SpecifyWhite 3 Widowed 4 Divorced Completed le. Decedant's Usual Occupetion (Giva kind of work dona during most of working iffa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) 12 Office Secretary 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maldan Surnama) Be Robert Jones, Marie E. Dean 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 23 7 19e. Informant's Name/Ralationship (Type, Print) 9106 Abigail Drive, Apt. 2 D, Balto., Md Linda Jones Niece 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Buriai 2 □ Cremetion 3 □ Ramoval from State 11-12-99 Elkridge, Md. 4 Donation 5 Othar (Specify) Meadowridge Mem. Park 22. Name and Addrass of Fecility Bradley-Ashton-Matthews Funeral Home 21. Signeture of Funarai Service Licenses C. Marsh Willow Spring Rd. Baltimore, Md 23a. Part1. Entar tha disease, or complications that caused tha daath. Do not enter the moda of dying, such es cardiac or raspiretory arrast, shock, or haart failura. List only ona causa on aach lina. Approximate interval Batween Onset end Death Physician /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted the burial-fransi Sequantially list conditions, if eny, leading to immadiata ceuse. Entar Undarlying Cause (Disaasa or Injury that initieted evants rasulting in death) Lest Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760. Due to (or es e consaquance of): attending | igned by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the caues of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 3 To the Hospital or Attending Physician: The law require within 24 hours efter death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 25. Was cesa rafarred to madical axaminer? Certification: To Be 28. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 1 A Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Yas 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicida 1½ Cartifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daeth occurred at tha tima, data and place, end dua to tha causa(s) and mennar stated. 29a. Cartifian Medical 29b. Signatura and titia of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 31. Data filed (Month, Day, Yaar) 32. Registrer's Signatura State 7 1999 Registrar

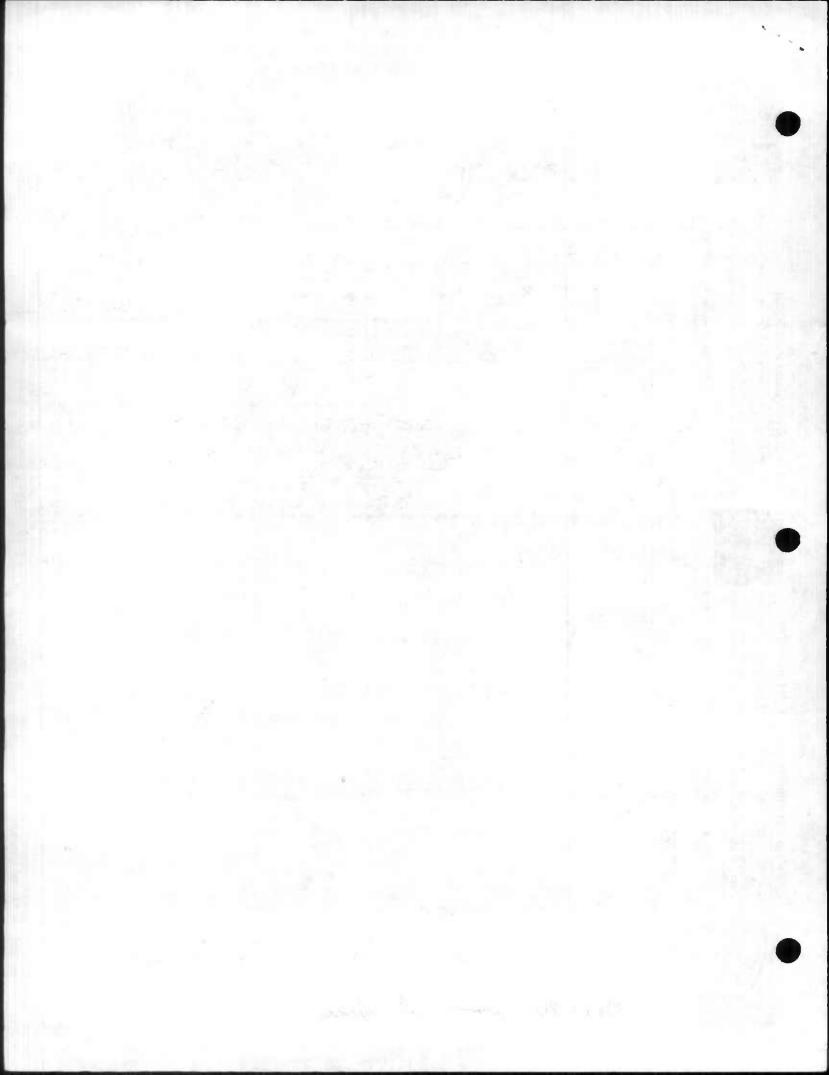
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State of Maryland / Department of Health and Mental Hygiene

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P.O.	Physician/W	Part II. Other significant conditions co	ntributing to death bu	t not result	ing in the underlyin	ig cause giv	en in Pert t.	1	,		the cause of death?
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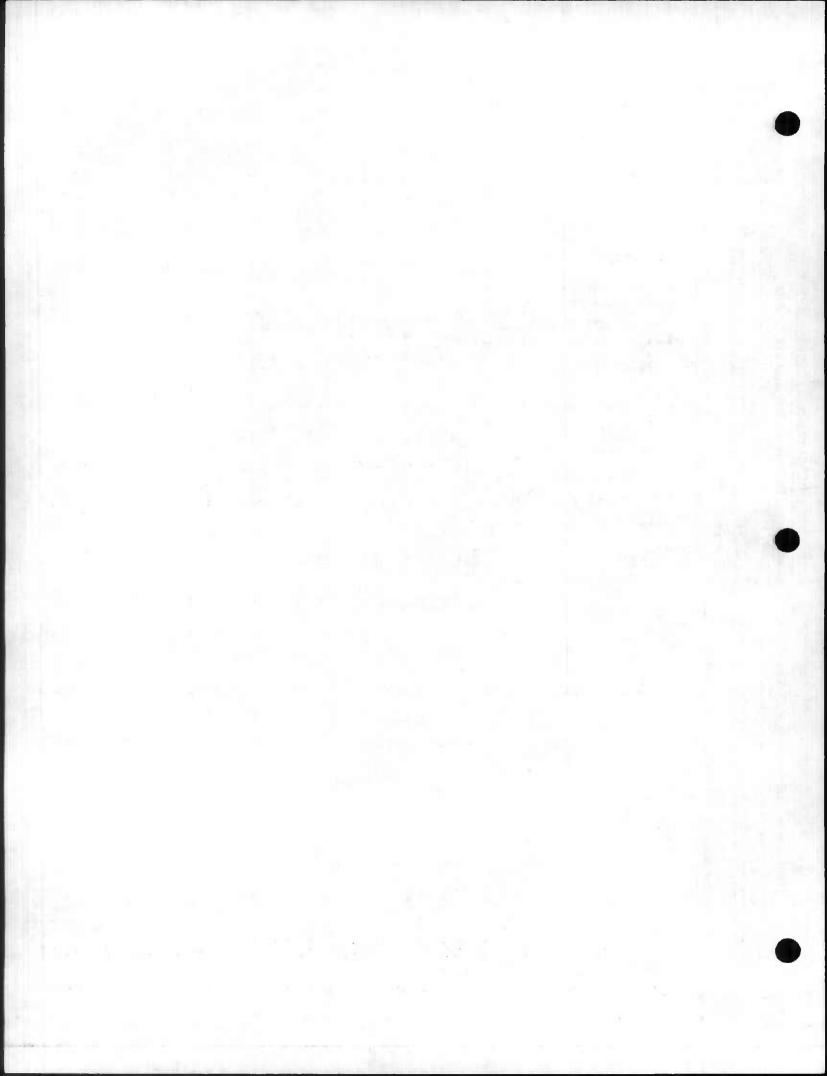
ting, Jack Thomas



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 13, Louis 8:05 AM G. Kelbaugh /Medical 4b City, Town, or Location of Death 4c County of Deeth 4a Facility Name (If not institution, give street and number) Examiner TOSE da le
Il Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Hos Pital ranklin )quare enter timore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Days 1 □XM 2 □ F 72 Director 215-28-7046 November 19, 1926 Maryland **Usual Residence of Decedent** death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits man be notified at 1 ☐ Yes XXNo Director Maryland | Baltimore 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 2232 Coralthorn Road United States Funeral 21220 r then "naturel", or items: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hyglene. Laborer Bethlehem Steel Corp. merked other Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Peges 1 and 2 abould be in nent of Health end Mental I Edward Kelbaugh Marie (unavailable) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mem 27 le 2232 Coralthorn Road, Baltimore, Maryland Madeline H. Kelbaugh (wife) 21220 other t more. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6 **Separtment** 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 11-17-99 Dundalk, Maryland Baitin 21. Signature of Funeral Service Licenses 22 Name and Address of Fecility CAFA, Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) days Examiner Physician/Medical Examiner physicien and the burial-transit The law requires that the death cartificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Due to (or as a consequence of): for usa 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I signed by t 3 Probably 4 Unknown 1 X Yee 2 No Records, ρ 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 hes 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 2 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel
2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after deeth. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) \$ 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 10 Vovember 13, 66 cause of death (Item 23a) (Type, Print) Name and address of person who compl Saltimore, Maryland 21237 Franklin 000 Hnita quare 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Lever Registrar



State of Maryland / Department of Health and Mental Hygiene

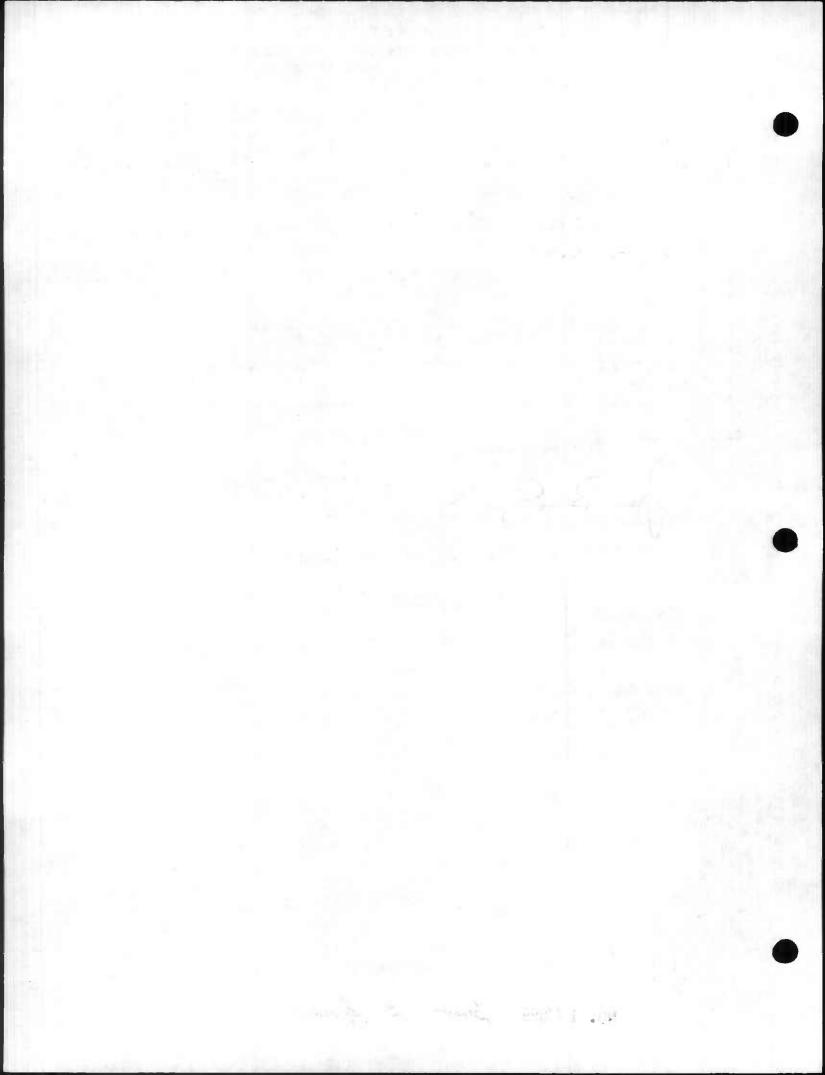
36071 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death November 15, 1999 **Physician** Beulah Maxine Kitzmiller 10:40 PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7019 Greenbank Road Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 1, 1918 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1□ M 21 F Maryland 219 34 0767 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flame 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 E No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7019 Greenbank Road 21220 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife . Peges 1 and 2 should be filed with ment of Heelth and Mental Hygien tant: If Item 27 is marked other the jury or other traumatic event, the Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Uriases Sines Dora Rodaheiver 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Wallace (son) 7019 Greenbank Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Holly Hill Mem. Gardens 11/18/99 Baltimore County, Md. 4 Donation 5 ☐ Other (Specify) 21. Sig ure of Funeral Applica Licenses Bruzazinski Fuheral Home PA Eastern Avenue Essex, Maryland 21221 efficietions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. ter the disease, or com, or heart failure. List only Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel year disease or condition resulting in death) **Examiner** Examiner gear The law requires that the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed page 2 hes 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Netural 5 Pending investigation To the Mospital or Attendit within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) a Rd. Balto astro Miaye 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State 1 7 1999

**DHMH 16 Rev 6/95** 

Registrar

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			AMEND#10c PER A.B. G777 11-17-99 J.A. Certificate of Death	ental Hygle Reg.	33	36073
			Decedent's Name (First, Middle, Last)	2. Dete of Deeth		3. Time of Death
	Physici /Medi	_	Alexander Love	Month eptembe	r 24,19	99 12:10AM
Y	Exami		4a Facility Name (If not institution, give street and number)  4b. City, Town, or Loc		4c. County of De	
			Mariner Health of Southern Maryland   Clinton	I	Prince	George's
	Funeral		Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye	9. B	irthplace (Stete or Foreign Country)
	Director		379-20-9323	03/30/1	925 Mar	yland
	B		Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location			10d. Inside City Limits
	Mary A P	ò	MD Prince Georges Eorrestville FORESTVILLE	:		1 ☐ Yes 2 ☐ No
	25 5	Director	10e. Street and Number 10f. Zip Code		. Citizen of Whet C	Country?
	3a o	0	6026 Parkland Court #201 20747		US	Δ.
	E B	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Speff Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-		nerican Indian,
0	within 72 hours attar death with the Maryland ans. Than "Latural", or thems 23s or 28s-( show the Madical Exercises must be notified at	F	1 Never Merried 2 Married 1  Yes	nouri, oto.,	Specify:	me, etc.
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ary	a mer	-	19e. Informant's Neme/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural	I Route Number, C	ity or Town, Stete	Zip Code)
	Tand 2 Health e am 27 le other tra		Lawan Poole/neice 10771 Esprite Place	White P	lains, M	D 20695
w .	Permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiana. Important: If Itam 27 Ia marked other than any Injury or other traumatic avant, the Im- page.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State  20b. Plece of Disposition (Name of cemetery, cremetory or other plece)	Date 20d	c. Location - City of	r Town, State
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ш	K & 2 0 Z		State Anatomy Board	d, 655 W.	Baltimo	re Street
			23a. Part Enter the disease, of complications that caused the death. Do not enter the model of bying, and a cardinal of a phock, or heer failure. List only one cause on each tine.	respiratory arrest.		Approximate tnterval Between
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1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Gretn	-	1010
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ć	a and in and in in in in in in in in in in in in in	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			1020
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1	a de la se	Med	one) and menner steted.		. Date signed (Mo	
	3 1 8	-	29b. Signature and offin of certifier 29c. Icense number	250.	// //	00
		-	THE MELLING DECENT	/)	11.7	77
			30. Nime and address of persoft who completed cause of death/(ttefn 23a) (Type, Print)			/
	Sta	te	31. Date lifed (Month, Day, Year)			
	Registr		NOV 1 6 1999 Server B. spark			

NOV 18 1939 James B. Ander

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month De Dey 1:22 P.M. LEONARD H. LINDNER 4e Fecility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth NORTH ARUNDEL HOSPITAL Glen Burnie Anne Arundel 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth 6/10/19/29 9. Birthplece (State or Foreign M) Sountry) 7. Age (In yrs. lest birthdey) 1**X**|X/1 2□ F Months Devs Hours 70 Yrs. 213.26.4547 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21061 USA 107 Dickens street 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritel Status Black, White, etc. XX Yes 2□No If Yes, Give Year or Dates: 47 - 49 1 Never Married Married 1 Yes 2 XX WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Dispatcher Roadway Express 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Marie Kaiser Henry L. Lindner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 107 Dickens Street, Glen Burnie, MD 21061 Ida M. Hall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State 5 Other (Specify) 11.18 Elkridge, MD 4 Donetion Meadowridge Mem. PK. Runeral Service Lice 22. Neme end Address of Facility Fink Funeral Home, PA 426 Crain Hwy., SW., Glen Burnie, MD 21061 Kelly Gregory Fink Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, or heart failure. Let only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) 23b. Did tobacco use contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24e. Wes en autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause 1 ☐ Yes 2 1/10 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) examiner Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpetient 3 DOA 1 Dipatient 27. Manne of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

physician and the burial-transit certificate be exe P.O. Box 68760. 60 USB ö Division of Vital Records, 8 page 2 s has funeral director this

Examiner Physician/Medical 2 Completed Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Directo

Funeral

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Completed

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiena.

Department of Health and Mental Important: If Item 27 is marked of

injury or

any

**Physician** /Medical

Examiner

Pages 1 and 2 should be filed within

altimore.

with the Maryland

INDINER

or Attending Physician: after death. 24 hours a Hospital within 2 \$

State Registrar

Medical

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner. On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29d. Date signed (Month, Dey, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

Burne ms.

of person who completed cause of deeth (Item 23a) (Type, Print)

Day, Year)

32. Registrer's Signature 30. Neme end addéss MOR

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

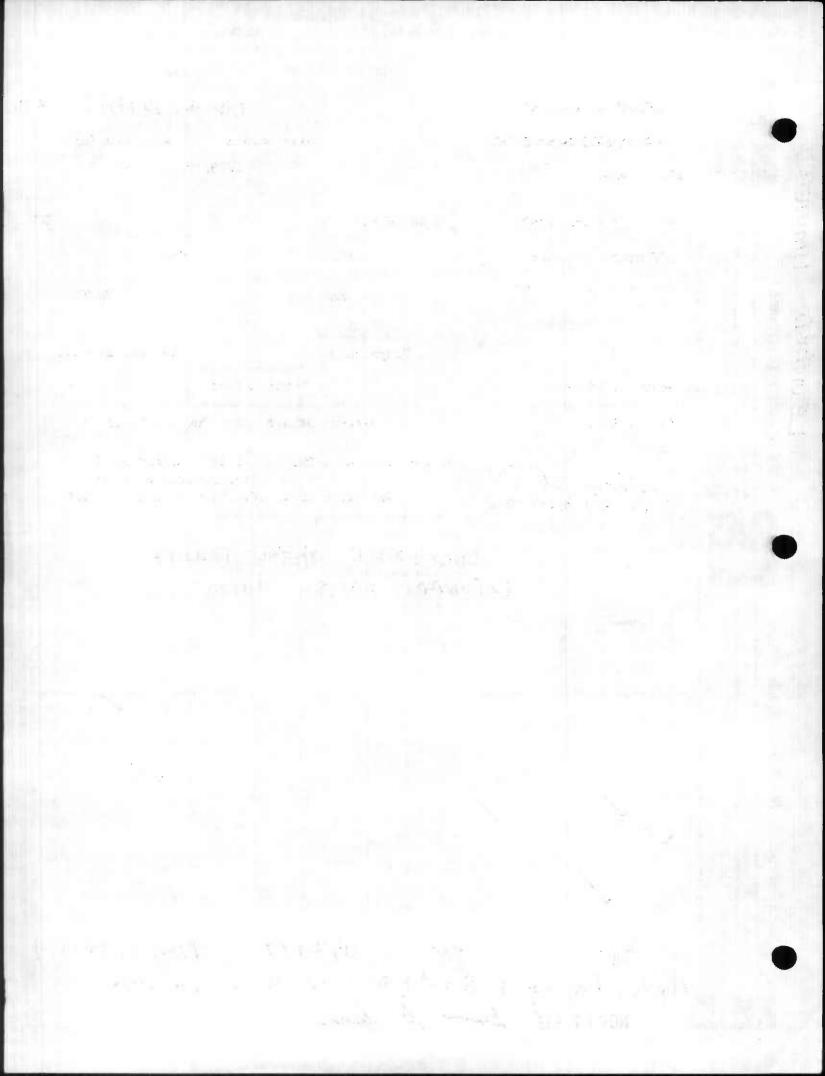
(Check only one)

29b. Signature end title of certifier

31. Date filed (Month, Day, Year)

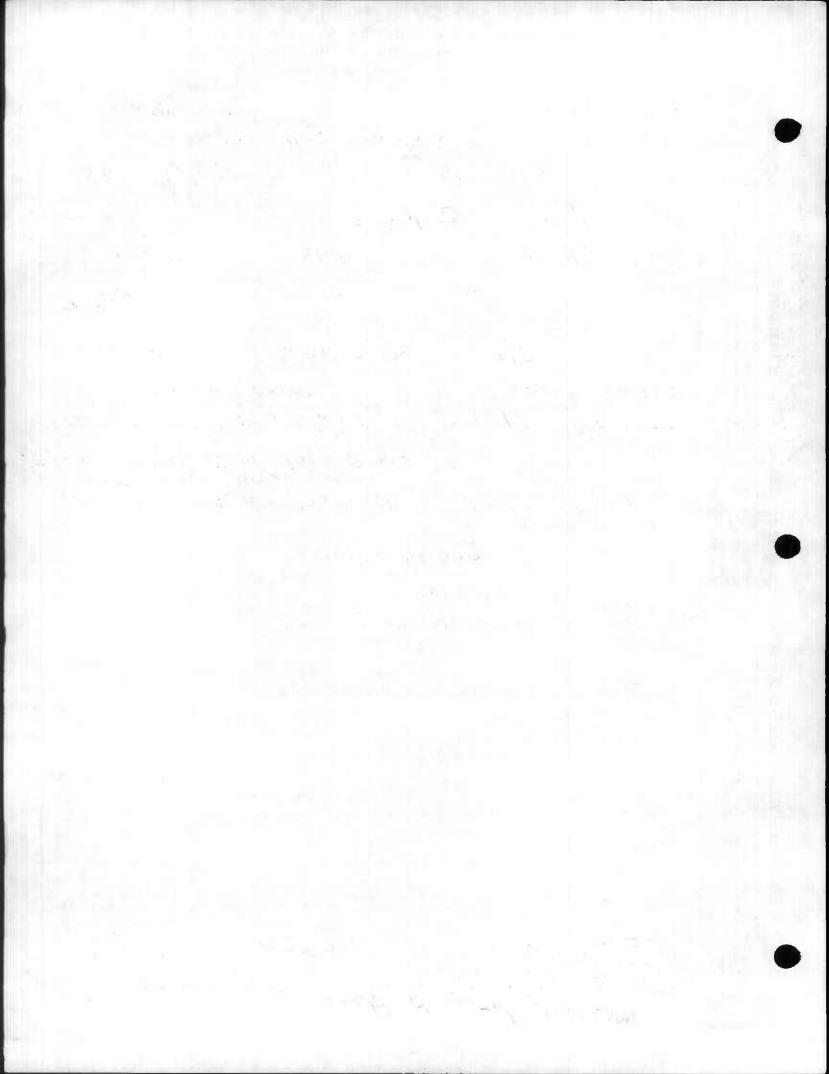
Dogwe

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 99 86075

	C	ertificate of Death	Reg. No.	
hysician	Decedant's Nama (First, Middla, Last)		2. Data of Death Month Day	3. Tima of Death
iician idical	Aubrey LAWSON		November 12, 14	199 800 pm
ner	4a Facility Name (If not institution, give street and number)	4b, City, Town, or Lo	ocation of Death 4c. County	of Death
	Maryland General Nos	ortal settomi	RLOH	
Ī	5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthdo	ay) If Undar 1 Yaar If Undar 24 Hrs.  Months Deys Hours Min.	8. Data of Birth (Month, Day, Year)	Birthplaca (Stata or Foraig Country)
ŀ	213-07-0771 MM 20F 95 Yrs	. Months Deys Flours Will.	2/12/04	NIC.
-	sual Rasidence of Decedant			
1	10a. States 10b. County 10c. City, Town or	Location		10d. Insida City Limit
U	Md. DIA BAH	MOIR		1 N Yas 2 N
106	e. Street and Number	10f. Zip Coda	10g. Citizan of V	/hat Country?
9	20 Mf. Holly St.	21229	1.5.	A.
11. 3	Marital Status 12. Was Decedant Evar in U,S. 1 Armed Forcas?	<ol> <li>Was Dacedent of Hispanic Origin? (Sp If Yas, specify Cuban, Maxican, Puarto</li> </ol>	ecify Yas or No-	- Amarican Indian, k, Whita, atc.
	1 Nevar Marriad 2 Married 1 Yas 2 No If Yas, Giva	1 Yas 2 No Specify:		$\alpha'$
	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:	TEL Tas 2840 Specify.	Specity	DIACK
	15. Decedant's Education 16a. Da (Spacify only highast grada complated) (G	cedant's Usual Occupation	16b. Kind of Bu	sinass/Industry
	Elamantery/Secondary (0-12) Collaga (1-4or 5+)	iva kind of work dona during most of work a. DO NOT usa ratired)		, ,
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17.	. Fathar's Nama (First, Middla, Last)	18. Mothar's Nam	a (First, Middla, Meiden Sumam	a)
	Edward Lawson	DAISEY	Onknown	
ľ	19a. informant's Name/Ralationship (Typa, Pnnt) 19b. M	ailing Address (Street and Number or Aur	ral Routa Number, City or Town,	Stata, Zip Coda)
	SARAh Allen (daughter) 90	20 Mt. Holly St. BA	Himore, Maryla	nd 21229
ŀ	20a. Mathod of Disposition 20b. Placa of Disposition	sposition (Nama of crematory or other place)	Data / 20c. Location -	City or Town, Stata
	1 La Buriai 2 Li Cramation 3 Li Hamovai from Stata	ion Cometery !	11/19/99 Baltin	re Marulan
ŀ	21. Signature of Funaral Sarvice Licensae	22. Nama and Addrass of Facility	He Supech A	1 14/19/14/11
		50	To rune 4	10me
-	July Comarlel	1129 N. CArolines	A. Baltimore, A	d. 21213
	23a. Part1 Enfar tha disaase or complications that caused the death. Do not shock of heart failure. List only one ceuse on each line.	antar tha moda of dying, such as cardiac	or raspiratory arrast,	Approximata Interval Batween Onsat and Death
	Acadina A	20/ 11/ 00		i ondat and boatt
l	Immadiata Causa (Final disaasa or condition rasulting in death)	Rhythmia		
ľ	Dua to (or as a con	saquance of):		
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634	Sequentially list conditions,  Due to (or as a con	sequenca of		
3	Sequantially list conditions, fany, leading to immediate ause. Enter Underlying cause (Disease or injury hat initiated avants  Dua to (or as a continuous)	al Parlure		
ŀ	that initiated avants resulting in death) Last Due to (or as a constant plant) Due to (or as a constant plant)	saquance of):		
	- v.			
	Part II. Other significent conditions contributing to death but not resulting in the	a undarlying causa givan in Part I.	23b. Did tobacco use con	tribute to the cause of death
			1 ☐ Yes 2 ☐ No	3 Probably 4 Unknow
			24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to
				complation of cause of death?
			1 ☐ Yas 2 ☑ No	1 □ Yas 2 No
-	25. Was cesa raterred to medicai	26 Place of Dea	th (Check only one)	
	axaminer? 1 ☐ Yas 2 ☑ No	Other	ome 5 Residence 8 Oth	ar (Specify)
1	- I when the state of the state	RIGHT 3LI DOA 4LI NUISING HO	28d. Dascribe how injury occur	
	27. Manner of Daath  1 Datural 5 Pending 2 Accident invastigation  28a. Date of Injury (Month, Day Yaar) Injure			
-	a Could get be		28f. Location (Street and Numb	er or Rural Routa Number.
	4 Homicide detarmined detarmined detarmined	, , , , , , , , , , , , , , , , , , , ,	City or Town, Stete)	
j	29a. Cartifiar 1D Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and piece	and due to the course(s) and ma	nner es stated
	(Check only one)  2 Medicat Examiner: On the basis of axamination and/or and manner stated.	r Invastigation, in my opinion, daath occur	red at the time, dete end place,	and due to the ceuse(s)
	29b. Signatura and titla of certiflar	29c. Licansa number	29d Data signer	i (Month, Day, Year)
	and the order of the order	0000-1	/	-100
		84350	11/15	199
	30. Name and address of period hatto complyind souse of death (itam 23a) (Type	pe Print - 1	d General	1/201/10
J	Dinesta ragas m.D.	40, Makyan	a General	HUSPITAL
	31. Data filed (Month, Day, Yaar) 32 Ragistrar's Signature	sparks		
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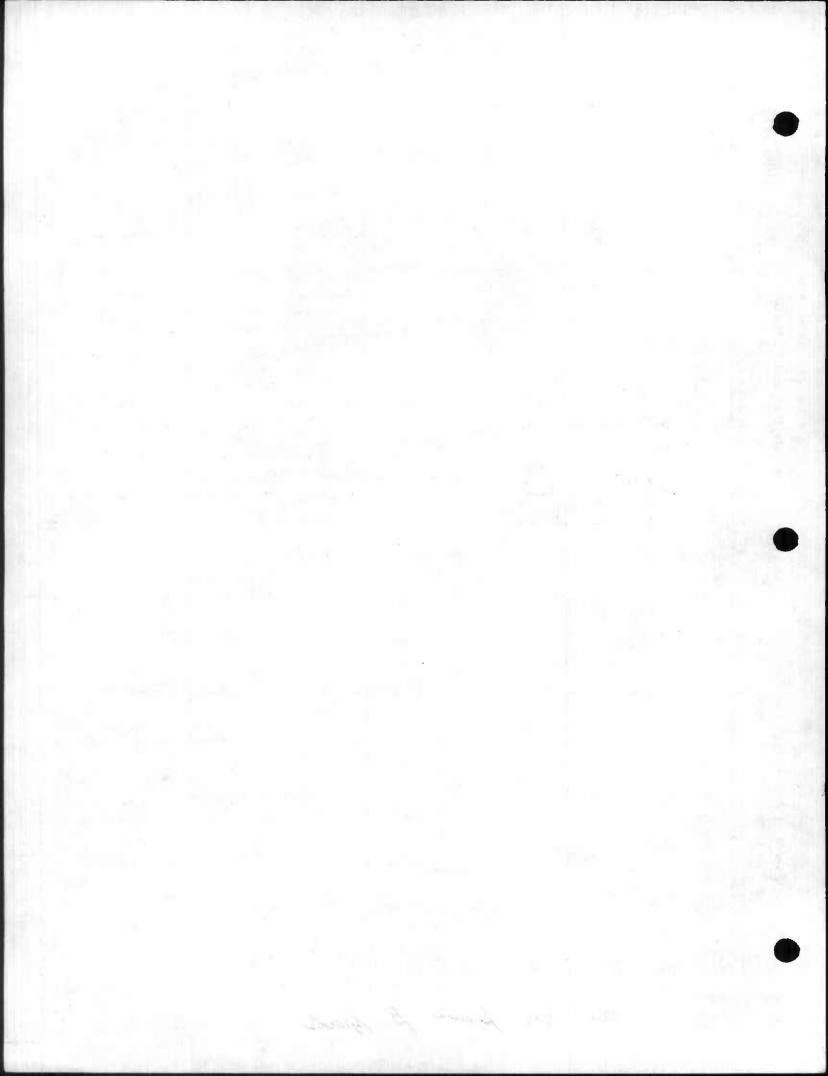
State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	Death	R	leg. No.		000.0
		1. Decedent's Neme (First, Middle, Last	)				2. Dete of Dee Month	th Day	Year	3. Time of Death
	Physician /Medical	STEPHANIE FAITH	MACDONALD				NOVEMBE		999	0730
	Examiner	4a Facility Neme (If not institution, give	street and number)			4b. City, Town, or L	ocalion of Death	4c. County		
		523 KENORA DRIVE				MILLERS	VILLE	ANNE	ARUNI	DEL
	Funeral	Sociel Security Number 6. Se		rs. last birthday)	If Under 1 Year Months Deys		8. Dete of Birth	Vose	9. Birthp	lace (Stete or Foreign
Ĺ_	Director	213.30.3/16	] м <b>2/ОХ</b> F	45 Yrs.	Months Deys	riouis Miri.	8. Dete of Birth (Month, Dey 1/15/1	954	MARY	ZLAND
	and and	Usuel Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
	ath with the Maryand 23a or 28a-f show Mat be notified at ral Director	MD ANNE A	RUNDEL	MILLERS	VILLE					1 ☐ Yes 2 ☐ No
1	or 28a-f s be notified Director	10e. Streef and Number			10f. Zip Code		1	log. Citizen of \	What Coun	ary?
	me 23a Cmust b	523 KENORA DRIVE			21108	3		USA		
21215-0020	ar, or harm Examiner.n by Fune	11. Meritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever it Armed Forces? 1 ☐ Yes 222 No If Yes, Give Yeer or Dates:		Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ck, White, WH]	etc.
2-0	ed within 72 hours ygiens. we then "netural", it, the Medical Exa Completed by	15. Decedent's Edu (Specify only highest grad			dent's Usuel Occu	pation during most of work	kina	16b. Kind of B	usiness/Inc	Justry
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ø.	Head	20a. Method of Disposition		b. Plece of Dispo	sition (Name of			20c. Location		wn, State
OL.	rages nut if h	1 Burial 2 Cremetion 3 F 4 Donelion 5 Other (Specify)		GLEN HA	VEN MEM.	PK.	11/17	GLEN B	URNIE	L, MD
Baltimore,	mir. Pa partmer portant y Injury	21. Signature Funeral Service Licen's		22	2. Neme end Addre	ess of Fecility FIN	NK FUNER.	AL HOME	. PA	
m	SOFFE	KELLY GREGORY	June -			HWY., SW.				21061
		23a. Part Enter the disease, or complished or heart feiture. List only or		eeth. Do nof ent	ter the mode of dy	ing, such es cardiac	or respirelory err	rest,	i	Approximete Interval Between
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ľ	Examiner	resulting in death)	Due fo	o (or es e consec	quenca of):		-1110			7,5
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/	physician and the burial-transit  calcal Examiner	Sequentially list conditions, if eny, leeding to immediate	Due to	o (or es e consec	quenca of):					
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O I	tate has been s page 2 should								of-	mpletion of cause death?
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vision	for: /	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	005 1 10 10			18- 4- N
	a fire death.  I Director: After ted in by the funare  Certification:	4 Homicide determined	28e. Pleca of Injury - A building, etc. (Spe		reet, factory, office		City or Tow		oer or Hurs	al Route Number,
-	Tilled O	29a. Certifier Certifying Phys	sician: To the best of my i	knowledge deet	h occurred at the ti	ime date and place	and due to the o	m bne (s)esue	anner es s	tated
1	white a respinal or American and the funeral Director: After this completaly filled in by the funeral Medical Certification:   Medical Certification: 3		ner: On the basis of examend menner sleted.							
4	Me thin	29b. Signature and title of certifier	100	1	29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
	0/	* Kundla	0116	/11/	m /	13150	1 1	1/arent	PM	16 1499
	10	30 Name and address of parsen who co	empleted cause of death (I	Item 23a) (Type,	Print)	21 - 3	<u> </u>	y dy conte		41111
		Kusse/1Rbel	reas MO /	6005.0	- rain H	- 1 ghway	, Gler	Buns,	4, st	2106/
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DHMH 16 Rev 6/95

Registrar

NOV 1 7 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MOND 1:50 AM MOV 160 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Packway or 6. Sex M Under 24 Hrs. etimore NURSING CONI If Under 1 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Year) Months 09-6696 1⊠M 2□F 202 - 09-669 Usual Residence of Decedent Pennsylvania Director with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits Herns 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 timor 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11 Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hyglene. Important: if Item 27 le marked other than "naturel", or itel any fujury or other traumatic event, the Medical Examine page. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Bethlehem Steel 12 Operator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Raymond 17abeth 2 aunders 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Rederick 20b. Place of Disposition (Name of Md 21234 NOV. 19 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) omoter 22. Name and Address of Facility Evans 21. Signeture of Funerel Service Licensee Funeral Chapel 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. 21234 Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final Prumania disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and certified his person of the transition of the funeral properties of the funeral director has been as the burnarial certification. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that influed events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Colon Cancer duri diation þ 24b. Were eutopsy findings available prior to completion of cause ot death? 24a. Wes an autopsy performed? Completed page 2 s 200 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3□ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 DNaturat 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 4. author C 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) NORTHERN PKWY Baltimore Mundo

**DHMH 16 Rev 6/95** 

State

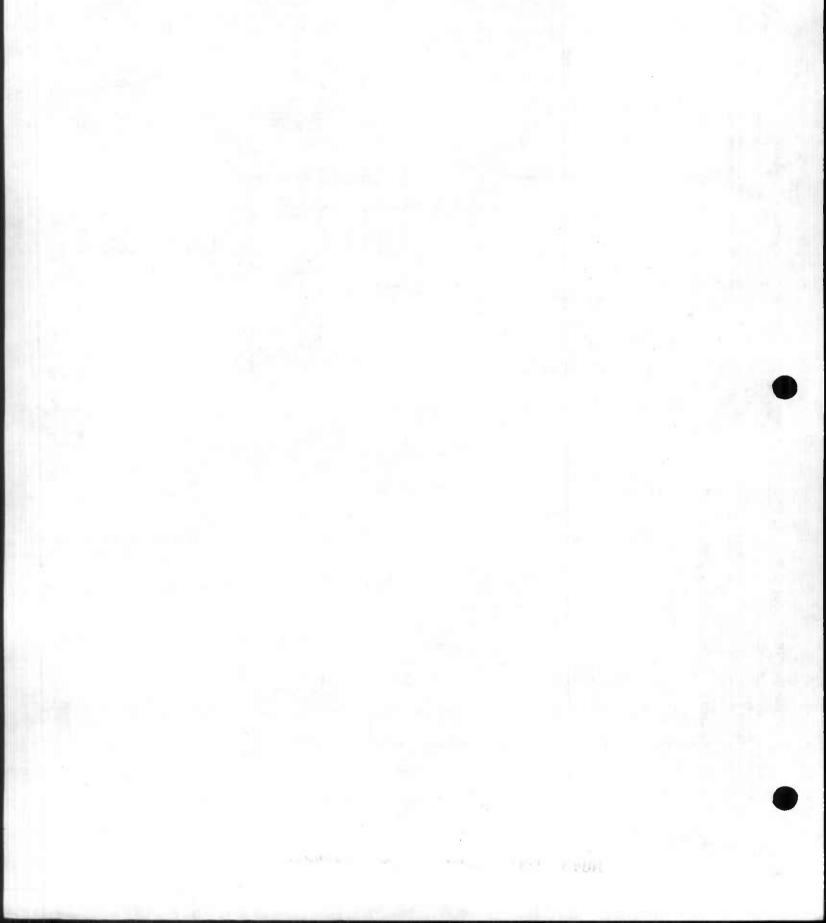
Registrar

31. Dete filed (Month, Day, Year)

NOV 1 7 1999

works

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** NOVEMBER 11, 1999 8:13 PM MASSUDA JOSEPH /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A LEVINDALE HEBREW HOME BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUL • 7,1922 9. Birthplace (State or Foreign Country) **Funeral** 1≅M 2□F Days Months Hours 77 EGYPT Director 213-60-0017 Usual Residence of Deceden Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f ahow maint be notified at 1 ☑ Yes 2 ☐ No Director MD N/A BALTIMORE the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 21209 U.S.A. 2901 FALLSTAFF ROAD #502 234 Funerai death нетв: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic avance. Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Merried 2 Married WHITE 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACEUTICAL 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (UNKNOWN) MASSUDA RACHEL ELLIOTT 19b. Meiling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2901 FALLSTAFF ROAD #502 - BALTIMORE, MD 21209 LOUISE MASSUDA / WIFE 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel Irom State 4 ☐ Donetion 5 ☐ Other (Specify) 11/14/99 ARLINGTON CHIZUK AMUNO BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 rocert 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final neumonid days disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician and the bunal-transit requires that the death certificate be axecuted Sequantielly list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avents resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 Yes Records, p 24b. Were autopsy lindings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? The law page 2 2 NO Karl 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 25(No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 (2) Neturel 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director n 24 hours after deve we Funerel Directo pietely filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medicai "Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and muriner steted. (Check only one) To the To the To the f 29b. Signeture e 29c. License number 29d. Date signed (Month, Day, Year) the of certifies

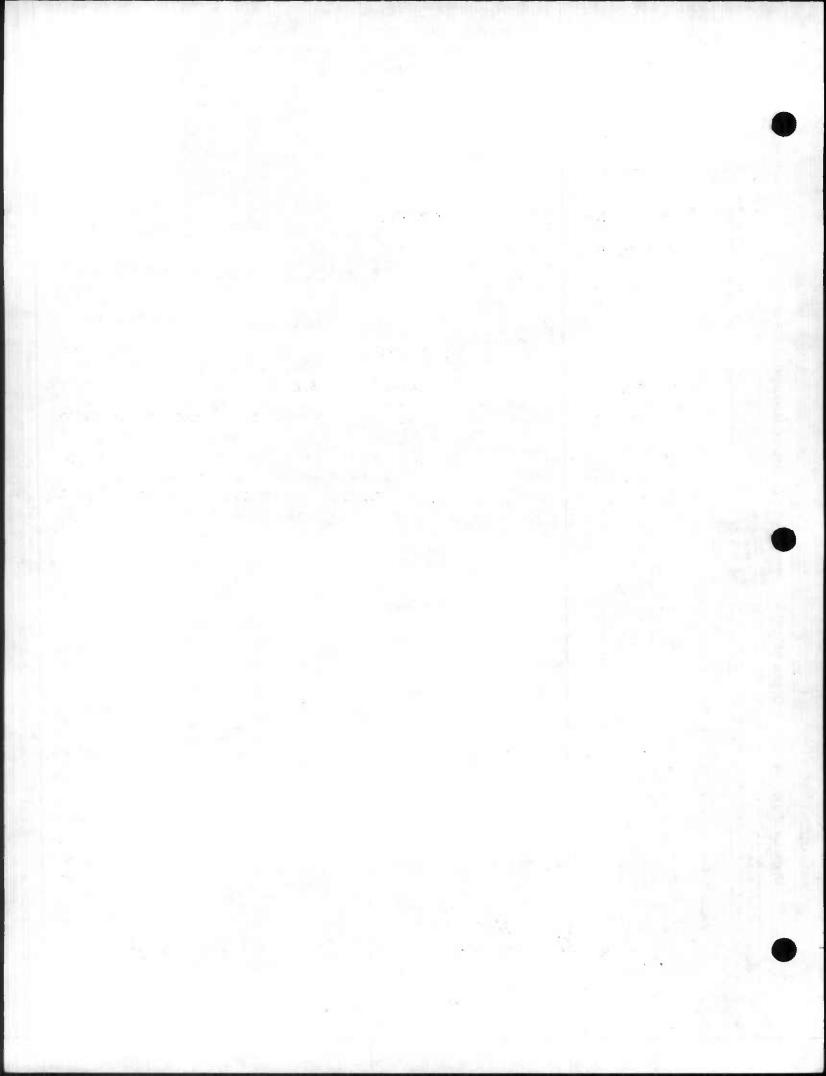
State Registrar 30. Na

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED #7PER LFH G777 11/17/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day Physician NOVEMBER 06 1999 :22Am 14 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner YVIKU If Und 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF 81 88 Yrs. Director 215-07-5163 28, JULY 1911 MD **Usual Residence of Decedent** the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or frems 23s or 25s-1 show treumstic event, the Medical Examinar must be notified at MD. BALTIMORE N/A 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1911 DUNDALK AVE. 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. 11 Marital Statue Bleck, White, etc. 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: WHITE 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Heelth and Mental Hyglene. Important: if Nem 27 is marked other than \*reny liury or other treumado event, tra Mad Bolida. Elementary/Secondary (0-12) College (1-4or 5+) TAILOR SEWING UKN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) å RAYMOND MANCUSO MARY MONTALTO 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LOUISE DUDA/SISTER 1911 DUNDALK AVE., BALTIMORE, MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 □ Cremetion 3 □ Removel from State 11/9/99 BALTIMORE, MD. OAK LAWN CEMETERY 4 Donetion 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility CHARLES S. INC. ZEILER & SON, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. BALTIMORE, 21224 MD. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) +JBOXMI Examiner Due to (or es e consequence of): Examine physician and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. certificate be Physician/Medical Due to (or as a consequence of) 980 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the th aigned by t d be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Š 24b. Were autopsy findings eveilable prior to completion of cause of deeth? bluode 24a. Wes en eutopsy performed? Completed 8 1 ☐ Yes 2 ☐ Ne 1 ☐ Yes 2 ☐ No Division of Vitai Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes ZENo FE Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Hospital or Attending 1 Matural n 24 hours efter deeth.

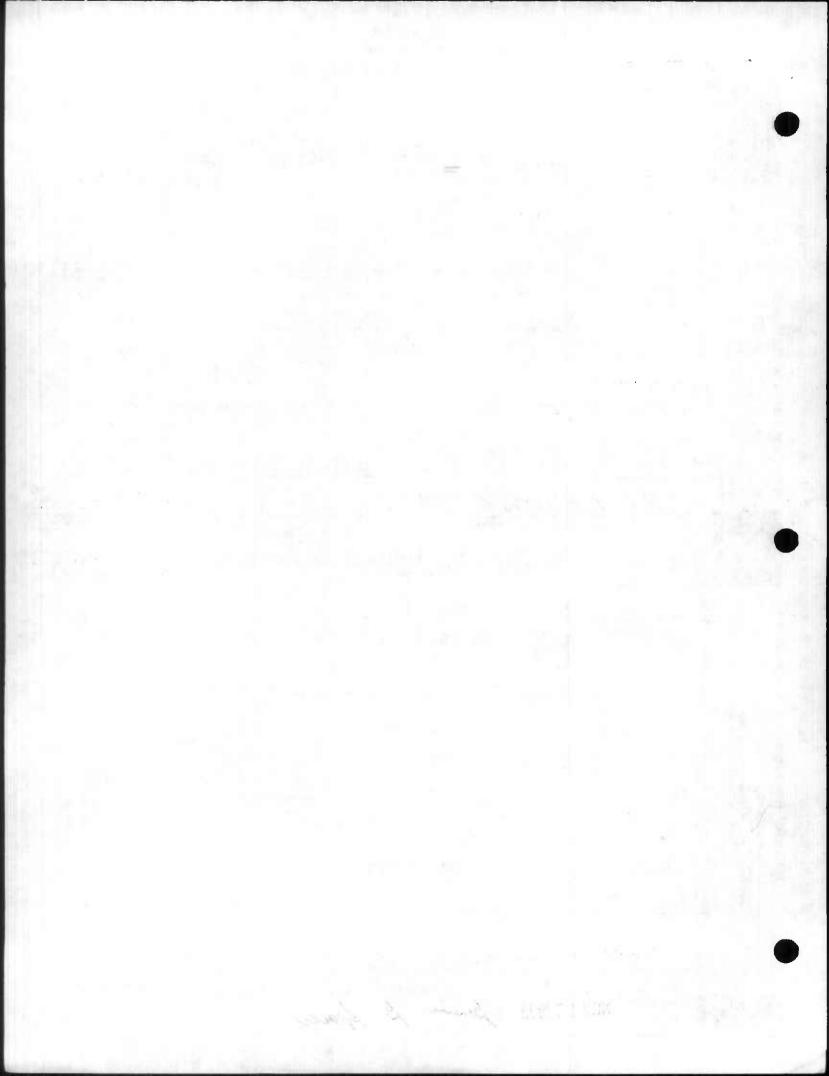
Ne Funeral Director: Afte betelv filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide Placa of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Scertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBE me and address of person who completed cause of de n 23a) (Type, Print)

State Registrar

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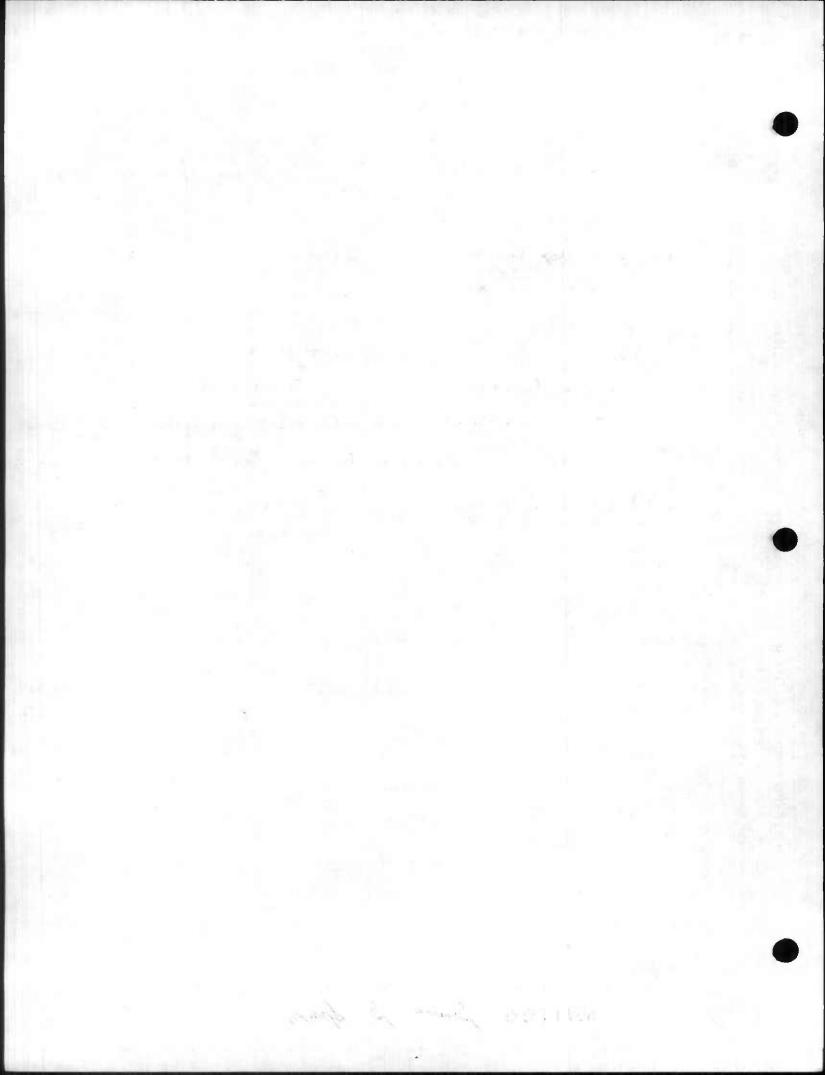
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32. Registyte's Signature



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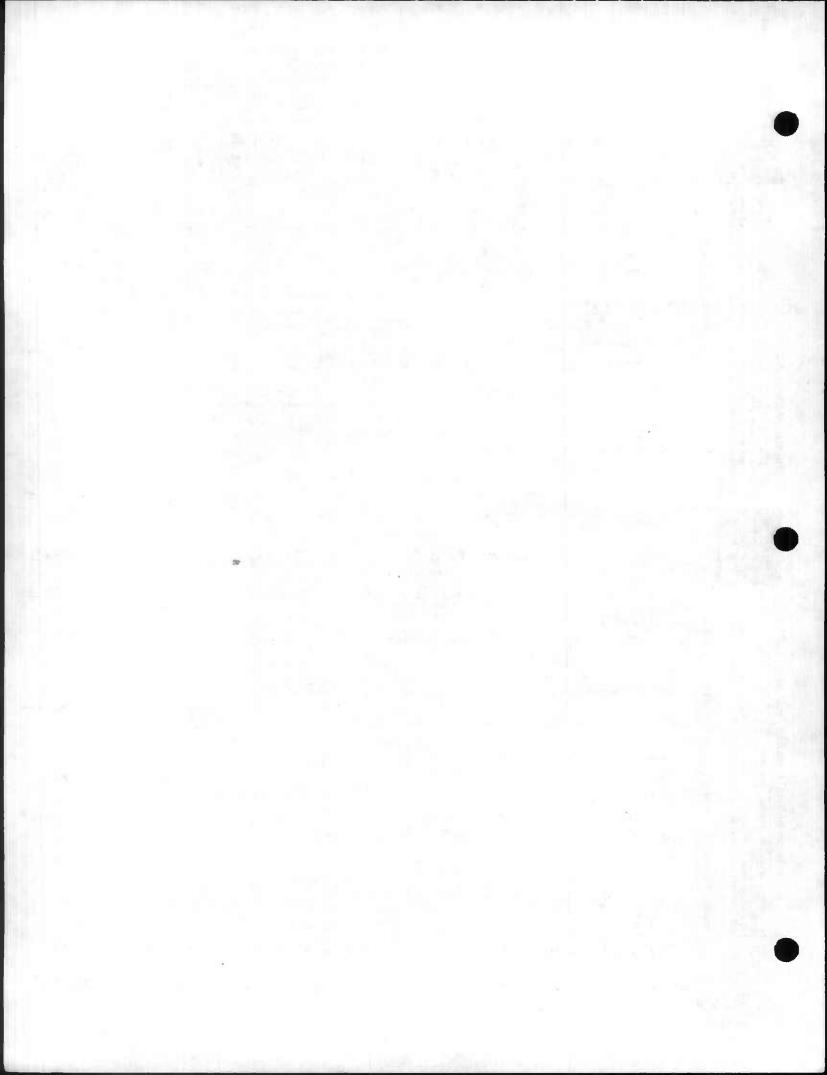


State of Maryland / Department of Health and Mental Hygiene

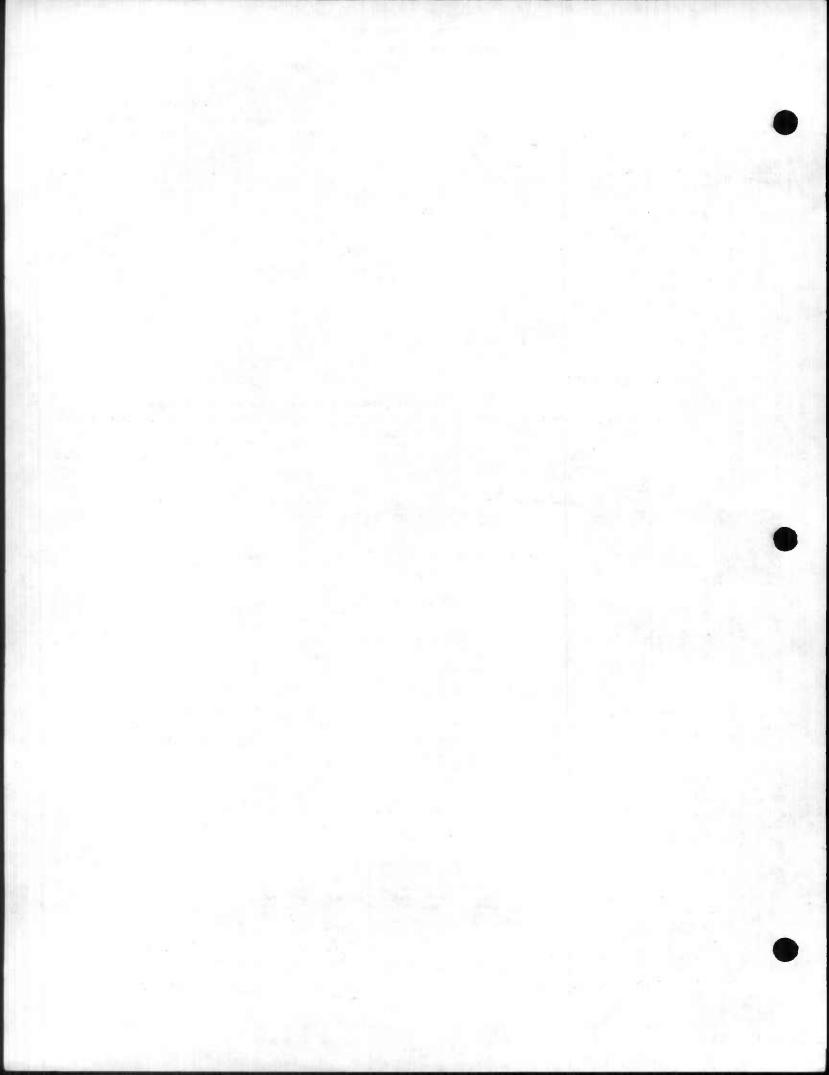
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DIVISION OF VITAL RECORDS, I or Attending Physicien: The law requires thater death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a limited to be the funeral director.		3 Sulcide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Specia	ome, ferm, street, fe	ctory, offic	9	28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rural Ro	ute Number,
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DHMH 16 Rev 6/95

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20a. Marthood of Disposition Surface (Prior Town, Siete 20b) 20b. Marthood of Disposition (Prior places) (Prior	lary	shot send N											
Company of the place   Company of the place		and m 27 her tr			ATTY / DAU				E DRIVE,				
A 21 CRAIN HWY., S.E., GLEN BURNIE, MD 21061	timor	Eart: If ite		1 ☑ Burial 2 ☐ Cramation 4 ☐ Dopation 5 ☐ Other (St	pecify)	Stata	cematary, c	rematory or other pla IDGE MEM.	PK.				
Physician //kedical Examiner    Part   Comment   Part   Part   Comment   Part   Part   Part   Comment   Part   Part   Part   Part   Part   Comment   Part	Bal	Depar Impor eny in		21. Signature of Funeral Service I	Densee	_		KIRKLEY-R	UDDICK FU				21061
Immediate Causa (Final designs or conditions)  Beautiful and continued in ideality in designs or conditions contributed to the cause of consequence of):  Beautiful and contributed to the cause of contributed to the cause of consequence of):  Beautiful and contributed to the cause of contributed and contributed and contributed and contributed and contributed and contributed and contributed and contributed and contributed an				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on a	used tha dea ach lina.	th. Do not e	enter tha moda of dy	ing, such as cardia	c or raspiratory	arrast,		Intarval Batween
Section   Control of the control o				Immediata Causa (Final								1	
Sequencially list conditions, and consequence of the property of the initial december of the property of the p				disease or condition resulting in daeth)	a. CHRON				NARY DISI	CASE	-	1	8 YEARS
Cause (Disasae or injury to get a sea or inju	-	ס ב	Iner										
ON ONE of the first of the control	30,	e execute tien end turiel-trans	I Exam	Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause. (Dissass or injury)	0.	Dua to (	or as a cons	sequence of):					
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HYPERTENSION   1   Yes   2   No   3   3   Probably   4   U   2   No   3   2   No   No		certifi nding use as	M		d				15				
State   Stat		death e atte	sicia	Part II. Other significant condition	ns contributing to de	ath but not ra	sulting in the	undertving causa o	iven in Part I.	23b. Dio	tobacco use co	ontribute to	o the cause of death?
State   Stat	P.0	at the 1 by th etache	Phy					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10	Yee 2□ No	3⊠ Pro	bably 4 Unknown
State    State   Color	8 50	by									l oah w	and autonou findings	
25. Was case referred to medical axaminer?  1   Yes	Sor	been	etec									av	ailable prior to emplation of cause
26. Place of Death (Check only one)  27. Mannar of Deeth 1	Rec	has has	dmo								IV OMNO		
Comparison of the control of the c	tal		0	25. Was casa rafarred to medical					26 Place of De				J Fes 2LINO
1 Matural   2   Accident   3   Suicida   4   Homicide   5   Pending invastigation   6   Could not be datermined   28a. Place of Injury - At homa, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Rura	£ <	yalcle is cer direc	0		Hospital:	patient 2	] ER/Outpat	ient 3 DOA OI	han			nar (Specif	<b>'y</b> )
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)  LAWRENCE VIDAVER, M.D., 420 CRAIN HWY., SW, SUITE 3, GLEN BURNIE, MD 21061  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		nding Ph ath. r: After th		1 ☑ Natural 5 ☐ Pending		f Injury n, <i>Day Year)</i>				28d. Describe	how injury occur	rred	
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)  LAWRENCE VIDAVER, M.D., 420 CRAIN HWY., SW, SUITE 3, GLEN BURNIE, MD 21061  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Divis	s efter de s efter de if Directo ed in by th	Sertific	datami	ned 288. Place	of Injury - At I g, atc. (Spec	noma, farm,	street, factory, office				ber or Rura	al Route Number,
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)  LAWRENCE VIDAVER, M.D., 420 CRAIN HWY., SW, SUITE 3, GLEN BURNIE, MD 21061  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		n 24 hour n Eunere sletely fille	edical	(Check only 2 Medical E	Examiner: On the ba	sis of examin	owledge, de etion and/or	ath occurred at the tinvestigation, in my	ime, date end plac opinion, deeth occ	e, end due to the urred at the time	ceuse(s) end m	enner as s and due to	teted. o tha cause(s)
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)  LAWRENCE VIDAVER, M.D., 420 CRAIN HWY., SW, SUITE 3, GLEN BURNIE, MD 21061  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To th To th com	29b. Signatura and titla of certifier 29c. License number 29d. Data signed (N							ed (Month,	Day, Year)		
LAWRENCE VIDAVER, M.D., 420 CRAIN HWY., SW, SUITE 3, GLEN BURNIE, MD 21061  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		10								99			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		7											
State		Sta	te					WY., SW,	SUITE 3,	GLEN BU	RNIE, MI	210	61
NIV / 1999 Pro / Pipodos		Registr		NUN	17 1999	Sen	wa	B. M	outs				



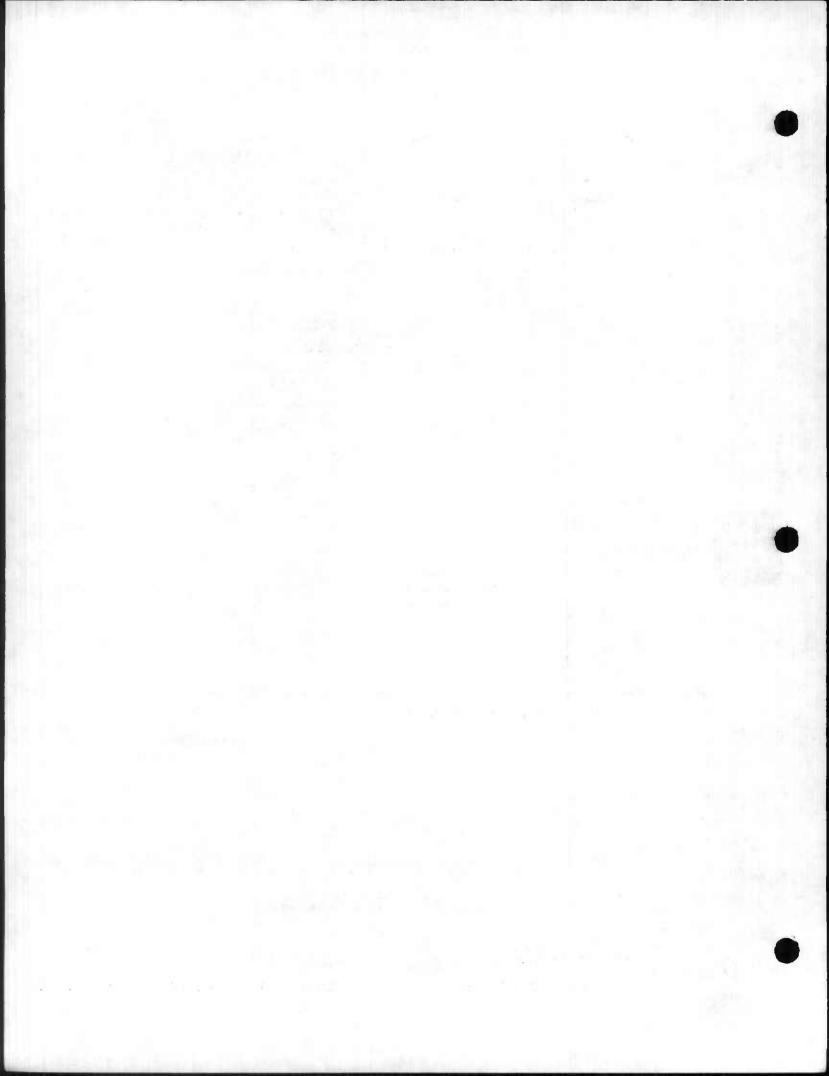
Ph	Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland		
	Department of Heelth and Mantel Hygiena. Important: If Item 27 is marked other than "naturel", or hams 23s or 28s-f show eny Injury or other treumstic event, the Heolosi Examiner must be notified at once.	Funeral Director	Exami

	Physiciar /Medica	n	ANNE	M •	PRIES							Month 11-	15-199	Yaar 9		ma of Death: 30 Pl
	Examine		566 W		VERSIT	Y PA	RKWAY			BAL	TIMO			of Death		
	Funeral Director		Social Security N 213-44	-9530 ¹	ex	Age (In yrs. 58	last birthday, Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Data of Bir (Month, Da 06-19	th y, Year) -1941	Cour	placa (Sintry) RYLA	AND
	Meryland ef ahow filed at	1	Oa. Stata  MD •	10b. County		10c. Cit	y, Town or L	ocation BALTI	MOR	E C	ГТY			1		de City Limits <b>V</b> as 2 □ No
	ifter death with the Meryler of terms 23e or 23e-f show one must be notified at	1	566 WE	mber ST UNIVE	RSITY	PARKW	AY	10f. Zip		1210			10g. Citizan of U •	S.A.		
020	of, or h	2	1. Marital Status 1 Never Marr	ied 2 Married 4 Divorced	12. Was Decede Armed Force 1 Tyes X If Yes, Giva Year or Date	S No	,S. 13.	Was Deced If Yes, spec 1 ☐ Yes X		spanic Orig n, Mexican, Specify:	in? (Spe Puerto	cify Yas or No Rican, atc.)	14. Rad Bla Specif	ce - Amaric ck, Whita, y: WH		
21215-0020	within 72 ene. then "net ne Medic	Completed	Elementary/Seco	15. Decedent's Ed city only highest gra andary (0-12)	ucation de completed) College (1-4	or 5+)	16a. Deca (Give life.	dent's Usua kind of wor DO NOT us HOUS	rk done d se retired	luring most )	of worki	ng	16b. Kind of B	HON		I
Maryland	THO S		7. Father's Nama OLIVER	(First, Middle, Last) JACKS	N MAR	STON					's Nama LEAN		Maiden Sumar			
	and 2 shoelth end 27 is m or treum		JOHN S		(COUSI		415	NORT	HWA			MORE,	MARYI	AND,	21	
Baltimore,	nit. Peges 1 derment of He ortant: if Item	2		position Cremation 3  5 Other (Specify			Placa of Disponentery, cre	metory or or	ther plec	e) EMAT(	DRY	Data 11-18	BALTO	•		
Bal	permit. Pe Depertment Important: eny injury	2	1. Signature of Fu	Service Licen	500				RY	W. Ji	ENKI		D SONS			
	Physician /Medical	le	shock, or hea		one cause <i>on</i> eac	h line.					cardiac c	r respiratory a	rrast,		Interva Onset	ximata al Between end Death
	Examiner	r	isease or conditions of the condition is suffing in death)	in	a	Dua to (o	or as a conse		ARC	TION				1	YEA	NUTES
oʻ.	physician and the burial-transit	E Adilli	sequentially list co	nditions, nmediata	b		r es a conse	quence of):						1	IEA	CM
Box 68760,	certificate be iding physicia ise as the bur	THE PROPERTY OF THE PROPERTY O	any, leading to in ause. Enter Unde ause (Disease or at initiated events esulting in death)	injury	d	Due to (o	r as a conse	quence of):								
P.O.	ed by the detached	P	ert II. Other signif	icant conditions co	ntributing to deat		ulting in the t		ause giv	en in Part I.			tobacco use co			
scords,	been lead											24a. Was	an autopsy rmed?	av	ailable p	opsy findings prior to n of cause
Vital Record	certificate has rector, page 2		5. Was case refer	red to medical						26. Placa	of Death	1 (Check only	Yas XX No	1[	□Yas	2 No
o	S = 0	2	axaminer? XIX Yas 2□ 7. Manner of Deat XIX Natural	h 5 Pending	28a. Data of I (Month,		ER/Outpatie 28b. Tima o Injury	of 2	8c. Injun World	er: 4□ Nur rat c?	sing Ho	na <b>XX</b> Rasi	dence 6 Ott	-	(y)	
Division	tal or Attending P rs effer death. el Director: Affer t led in by the funer. Certification:	The state of the s	2 Accident 3 Suicide 4 Homicide	investigation  6 Could not be determined	28e. Placa of	Injury - At he etc. (Specif		M reet, factory		Yes 2□N		28f. Location ( City or To	Street and Num wn, State)	ber or Run	a <i>l R</i> oute	Number,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Centification: 7		9a. Certifier (Check only one)	(1X) Certifying Phy 2 Medical Exam	rsician: To the be iner: On the basis and manner	s of axamina	wledge, deat tion and/or in	h occurred envestigation,	et the tim in my o	e, date and pinion, deat	place, a	and due to the ed at the time,	cause(s) and m data and place,	enner es s and dua t	itated o tha ca	use(s)
	Withir Comp		9b. Signature and	titla of certifier	Hes	Ih	the	290	License	number	94	133	29d. Date signe			
	0		Name and addr	ess of person who o	ombleted cause of		1 23a) (Type	Print	1 77		1035	ПОН	CON 1	Anur	2 37-	2104

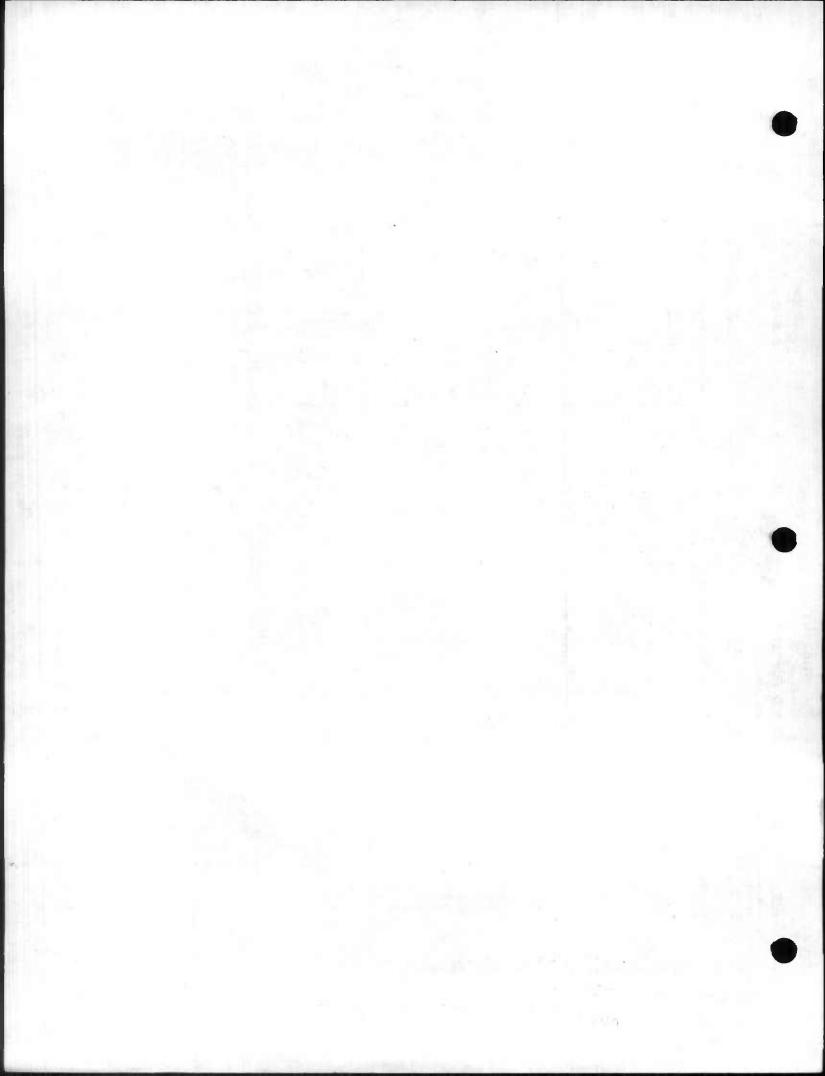
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State Registrar

31. Data tiled (Month, Day, Year)



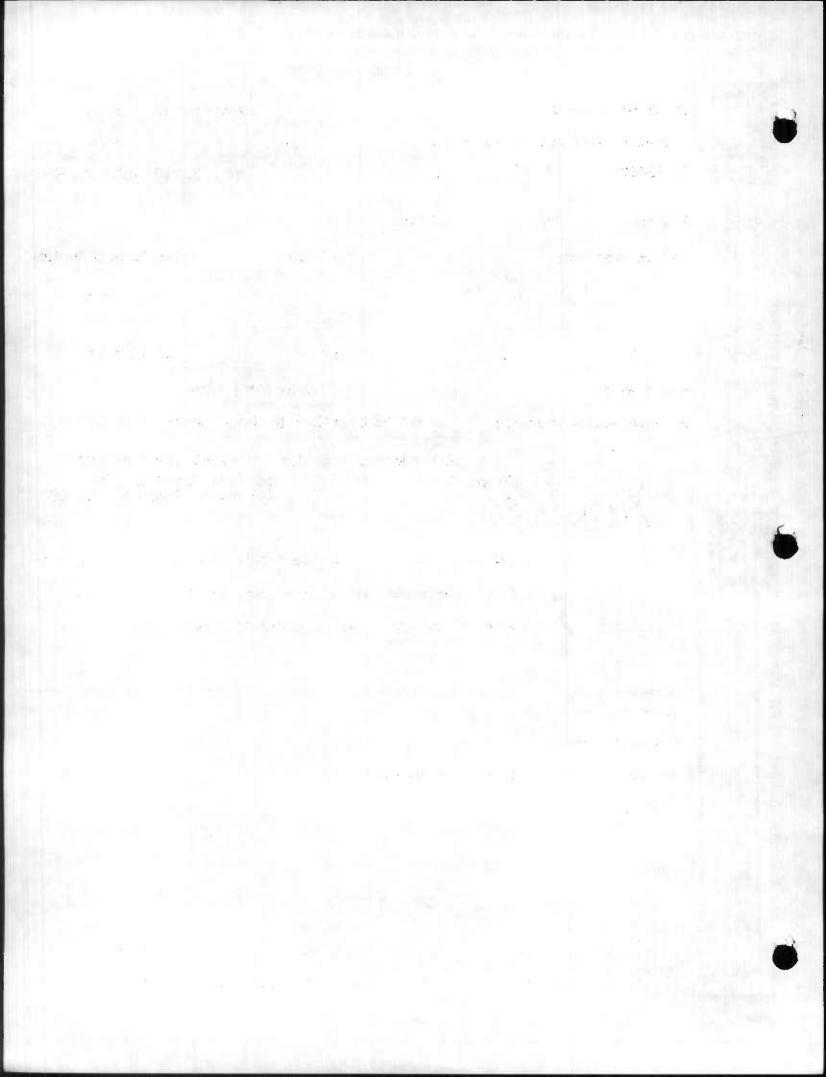
				State of Marylar		ent of Health an ate of Death	d Mental H	ygiene 9	9 36084
			1. Decedent's Name (First, Middle, La	st)			2. Dete of C	Death	3. Time of Death
Ш	Physic		GENEVA		F	PATTON	No VEM	PCP IN	1999 5:10 PM
	/Med Exami		4a Facility Neme (If not institution, giv	e street and number)		4b. City, Town	or Location of De		
	- ZAGIIII		2107 W.	FAVETTE	STREE	ET BA	LTIMOR	E	NIA
	Funeral		5. Sociel Security Number 6. S	ex 7. Age (In yrs	1 72 77 7	der 1 Year   If Under 24	Hrs. 8. Date of E		Birthplace (State or Foreign Country)
	* Director		218-28-5439	□M 2X(F	6 Yrs. Moriti	is Deys Hours	JAN	29,1933	MARYLAND
	pu ,		Usuel Residence of Decedent  10a. State 10b. County	100 0	ity, Town or Location				
	burs efter death with the Marylan ali, or frems 23a or 28a-f show Examiner must be notified at	-	Toa. State Tob. County	/ 4	12		- 1	/	10d. Inside City Limits 1/€ Yes 2 □ No
	No M	ecto	MARYLMO NI	A		LTIMOR	RE CI	77	
	No.		10e. Street end Number			Zip Code		10g. Citizen of \	
	234	Frai	2101W.F		REET	2/23	23	UE	
	her de	Funeral Director	11. Meritel Status	12. Was Decedent Ever in the Armed Forces?	If Yes, s	pedent of Hispanic Origin pecify Cuban, Mexican, P	uerto Rican, etc.)	Blac	e - American Indien, ck, White, etc.
20	rs eff	by F	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	1 Ves 2 No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify	BINAN
5-0020	within 72 hours efter death with the Maryland ena. than "natural", or items 23a or 28a-f show the Madical Examinat must be notified at		15. Decedent's Ed		16e. Decedent's U	suel Occupation		16b. Kind of Br	usiness/Industry
215	n n n	Completed	(Specify only highest gra	de completed)	(Give kind of life. DO NO)	work done during most of	working		,
21	filed with Hygiena. Wher that	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	CARE	PROVICE	FR	STAT	E HOSPITAL
	Hygin Hygin	Be C	17. Father's Neme (First, Middle, Last)	7			Neme (First, Midd		
lar	Mental Mental arked o	To B	ROV CLIF	TON YOUN	GER	WIL	LIE E.	STHER	TISPALE
Maryland	2 should be filed within and Mental Hygiena. is marked other than aurmatic event, the M		19a. Informent's Neme/Reletionship (	7	19b. Meiling Addre	ess (Street and Number of			
Z,	s 1 end 2 should be filed within f Health and Mental Hygiena. Item 27 is marked other than other traumatic event, the Ma		KELITA FIEL	D (DAUGHTER	3005	CATHERI	WE ST.	BALTI	HORE, HO. 212 City or Town, Stete
more	of He		20a. Method of Disposition	20b.	Place of Disposition (/	lame of place)	Dete	20c. Location -	City or Town, Stete
E	Peg Tr: H		1. Burial 2 □ Cremetion 3 □		T. 2101	CEMETER	V11-16-9	9 LANSI	DOWNE, MP.
alti	Department Important: any injury		2 Signature of Funeral Senior Licer						
0	88E 58		* Madell	~ )	000	EPHH.	OROWN	1201-11	NERAL HOME
			23a. Part Enter the disease, or companyout, or heart failure. List only	plications that caused the dee	th. Do not enter the m	ode of dying, such as car	rdiac or respiratory	arrest,	Approximate
	Physician		shock, or heart failure. List only	one ceuse on each line.					Interval Between Onset end Death
	/Medical		Immediate Cause (Final diseese or condition	-					!
	Examiner		resulting in death)	a. Squamous	or as e consequence	1			tup years
	D #	ner				,.			
	ta be axecuted ysician and na bunal-transit	Examiner	Sequentially list conditions,	b. Due to (	or es e consequence (	of):			
0,	ta be axe ysician a		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury						
8760,	5 5 5	dical	that initieted events resulting in deeth) Last	Due to (	or es e consequence o	f):			
x 68	requires thet the death certificet seen signed by the attending phy hould be detached for usa as th	Physician/Med		4					1
Box	ath co	lan		0.					
0	thet the death ed by the stre detached for	sic	Pert II. Other significant conditions of	ontributing to deeth but not re-	sulting in the underlyin	g cause given in Pert I.	23b. Di	d tobacco use co	ntribute to the cause of death?
9.	d by detac						18	Yes 2□ No	3 Probably 4 Unknown
Ś	ires the signed d be de	by							Tan
Records,	v require been sign should b	etec						es an autopsy rformed?	24b. Were eutopsy findings available prior to completion of cause
ec	2 S C	np							of death?
H		Completed					1[	Yes 2 PNo	1 □ Yes 2 □ No
Vital	Physician: The lithis certificate here director, page	Be	25. Wes case referred to medical examiner?	1)-2-1			Death (Check only	y one)	
of	hysi this c	မ	1 Yes 2 No				ng Home 5 12 Re		1 1 77
	After Uner	Certification:	27. Menner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describ	e how injury occur	Ted
Division	tend deeth tor: /	cat	2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be		М	1 Yes 2 No	004 Lasation	(0)	
Ξ	or At or At Direct In by	튙	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, ferm, street, fact fy)	ory, office		own, State)	ber or Rural Route Number,
	Hospital or Attending 24 hours after deeth. Funeral Director: After stely filled in by the fune		29a. Certifier 12 Certifying Ph	Valence Valenc	1-4 1	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	1		
	Hos Fun Fun	edical		yeiclan: To the best of my kno liner: On the basis of examina end menner stated.					
	To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	N N	29b. Signeture end title of certifier	GIO IIIGIRIBI SIBIBU.		29c. License number		29d. Dete signe	d (Month, Day, Year)
	F¥F8		10 1	A 1					
	10		Deurly &	Mickel		D029133		Nouce	Der 15, 1999
	4)		30. Neme and address of person who				•		1387
			31. Dete filed (Month, Day, Year)	10 600 Not		Sports Bo	more	Klaryle	13812 pa
	Sta Regist	_		32. Registrar's Sign	P	good			



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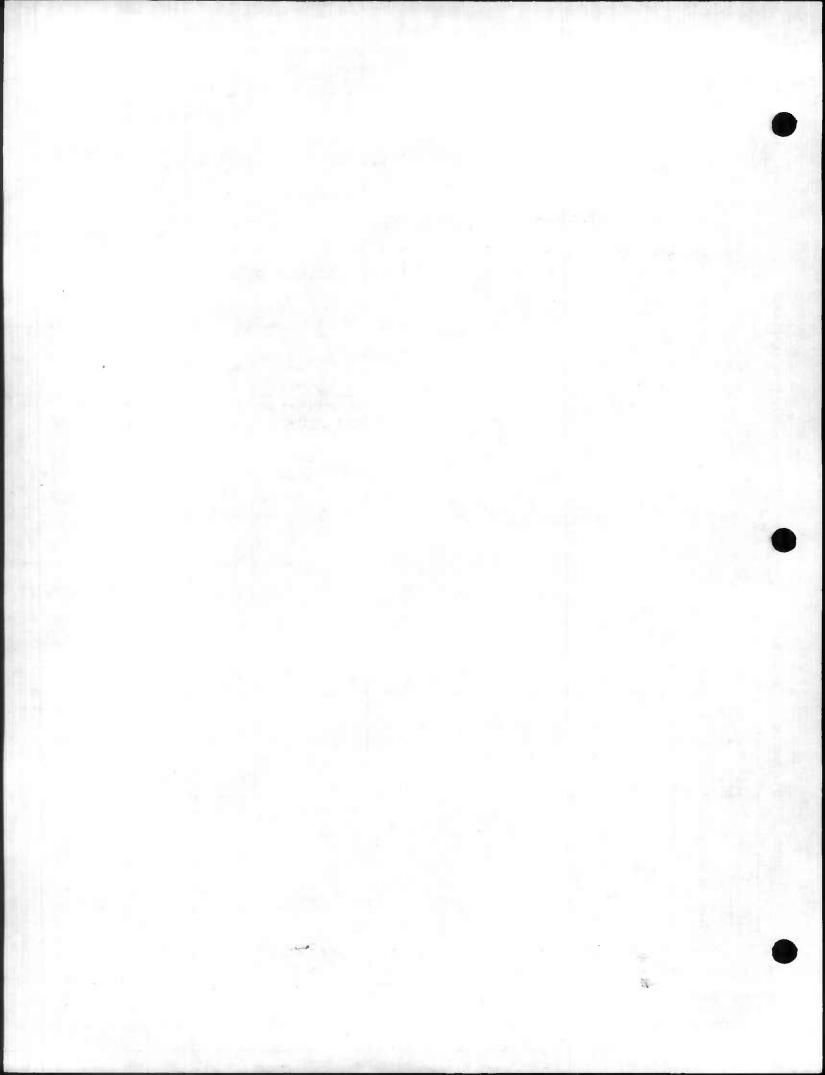
		State of	Maryland /		rtmen			and M	lental H	lygie Reg		) 3	6085
		Decedent's Name (First, Middle, Last)							2. Date of Month	Death	Day	Year	3. Time of Death
	Physician /Medical	Janice Ann Rosenzweig							Nover		•	1999	20:09
	Examiner	4e Fecility Neme (If not institution, give street end numb				4	b. City, Tov	wn, or Lo	ocation of De	eth		y of Death	
		Greater Baltimore Medica  5. Social Security Number 6. Sex 7.	.1 Center .Age (In yrs. lest)		If Under	1 Year	Tow:		9 Date of	Righ		Ltimor	
	Funeral Director	220-52-3540 1 M 2X F	49	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, April	Day, Y.	1950	Baltin	lace (State or Foreign try) More, Maryland
-	9	Usual Residence of Decedent  10a. State 10b. County	10c. City, To										
	faryla show			imore	cation							1	0d. Inside City Limits 1
	be filed within 72 hours after death with the Maryland tall Hyglana. diother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	Maryland N/A  10e. Street and Number	Dait.	IIIDIE	10f. Zip	Code				10g	. Citizen of	What Coun	itry?
	3a or	6351 Red Cedar Place				21209-	-3830			lh	ited S	tates o	of America
	r thems 23anner must	11. Maritel Status 12. Was Deceded Armed Force	ent Ever in U,S.	13. V				gin? (Spe	ecify Yes or Rican, etc.)		14. Ra	ce - Americ	an Indian,
20	or h	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2	IX No		Yes 2		Specify:	, , , ,	1110011, 010.7		Speci		
21215-0020	hours a Even	3 ☐ Widowed 4 ☐ Divorced Yeer or Date		Pa Danad	ant's House	I Coouna	tion			10		Business/Inc	
15	ed within 72 horygiana. Not than "naturalt, the Medical Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	kind of wor OO NOT us	rk done d e retired	ation <i>luring</i> most )	of work	ing	10	o. King of E	ousinessino	ustry
212	d within plans.	Elementary/Secondary (0-12) College (1-4	or 5+)		Atto	orney					Health	Care L	_aw
	be filed tal Hygi d other event,	17. Fether's Name (First, Middle, Last)					18. Mothe	r's Name	e (First, Mide	de, Ma	iden Suma	me)	
Maryland	2 should be filed and Mantal Hygi is marked other numatic event, To Be Co	Bernard Popick							ell Sen				
Mar	S es es	19a. Informant's Name/Relationship (Type, Print)  Mr. Norman Rosenzweig(Husband)			-				al Route Nur			n, Stete, Zip 1209–38	
	Haall m2 ther	20e. Method of Disposition	20b. Place	of Dispo	sition (Nam	ne of		bartii	more, M	-		- City or To	
non	0 0	1 ☐ Buriel 2 【Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate		vice (			1	1/18/19				
altimore,	in ju	21. Signature of Funeral Service Licensee Jeffrey							Towson				
ä	Depa impo eny ii	19Mm J. Gan						1050	York R	d.	Towson	, Md. 2	21204-2515
	Physician nucuicar Examiner	23a. Pert1 Enter the dissese, or complications that caushoof or need failure. List only one cause on each shoot or need failure. List only one cause on each shoot or need failure. List only one cause on each shoot of the cause (Final disease or condition resulting in death).	nary art  Due to (or as	ery	occ1u							1	Approximete Interval Between Onset and Death  terminal
Box 68760,	nat the death certificate be executed by the attending physician and letached for use as the bunat-transit Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate	ic veget  Due to (or es  ated inf  Due to (or as	a conseq ecti	uence of): ONS W		•						Days 1 year
	daath	Part II. Other significant conditions contributing to deal	th but not resulting	g in the ur	nderlying ca	ause give	en in Part I.		23b. D	id toba	ecco use c	ontribute to	the cause of deeth?
P.0	that tha da ed by tha a datached i	Pulmonary hypertension							1	☐ Yes	2 No	3 Prol	bably 4 Unknown
of Vital Records,	been sign should be	Gaucher's disease							24a. W	as an a	autopsy ad?	av co	ere autopsy findings ailable prior to mpletion of cause death?
Re	The law ta has age 2	Status-post total left h	ip repla	ceme	nt				15	Yes	2□No	12	TYes 2□ No
ita		25. Was case referred to medical					28. Plece	of Deat	h (Check on	ly one)			
× V			patient 2 ER/	Outpatien			4 🗆 140	-	me 5 R				y)
Division o	Aftar Auna funa	27. Manner of Death  1 X Netural 5 Pending investigation  2 Accident (Month,	Injury 28t Dey Year)	o. Time of Injury	M 2	8c. Injury Work	vat ∢? Yes 2⊡I		28d. Descrit	e how	injury occu	ırred	
Divi	Hospital or Attending 24 hours after death. Furerel Director: Attential filled in by the fune atlay filled in by the fune Jical Certification	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number City or Town, Stete)								ber or Rure	I Route Number,		
	Hospi 4 hou Funer taly fil	29e. Certifier (Check only one)  ** Certifying Physician: To the base and manne	is of examination										
	within 2 To the comple	29b. Signature and title of certifier			290	D28	number 3885				. / 16 / 1	ed (Month,	Dey, Year)
		30. Name and address of person who completed cause	,					D = 1	+1	_			14/15
	State	Howard L. Siegel, M.D  31. Date filed (Month, Day, Year)  32. Beg	istrer's Signeture					Dal	CTHOLE	= LIL	, 212(	<b>7</b> ₩	
	Registrar		mere ,	G.	100	uls	1.						
		110 1 1 1333 /			1								

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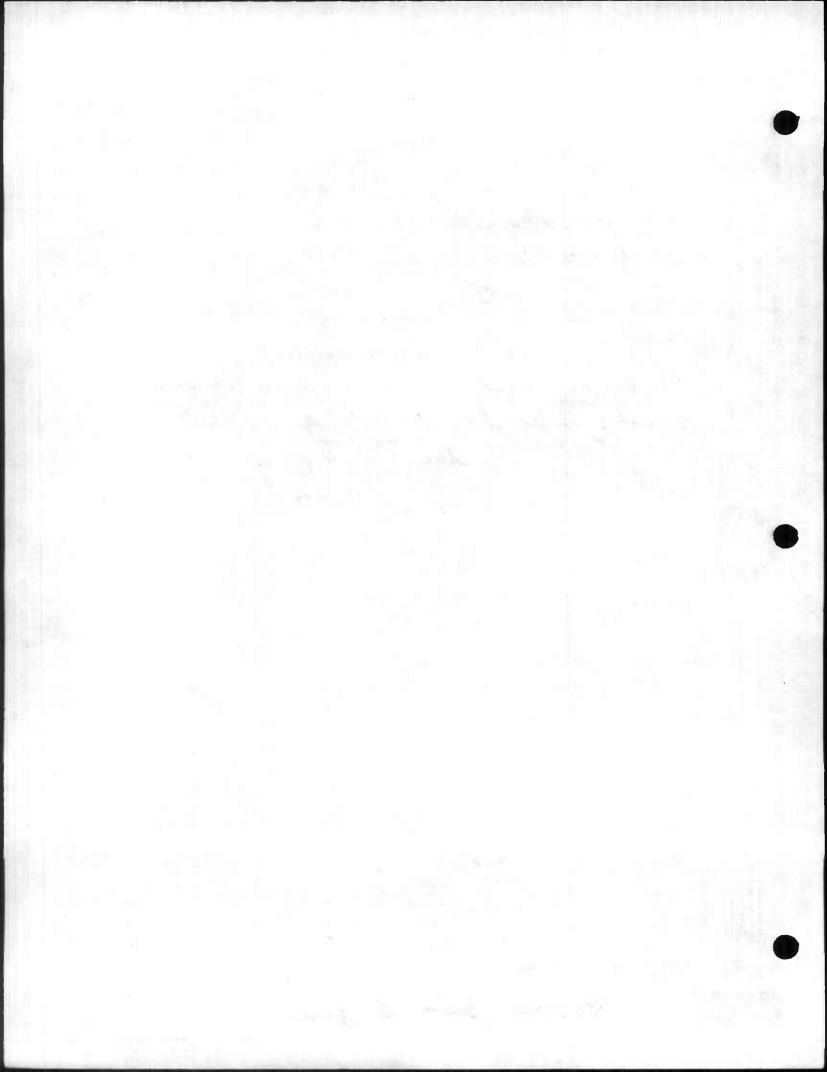


# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certifica	te of Death		g. No.
Phys /Me	ician dical	1. Decedent's Nama (First, Middle, Last)  Elaine Rudow		2. Dete of Death Month Novem	Day Year 3. Time of Death Der 15 1999 12:40 PM
Exam		4a Facility Name (If not institution, give street and number)  Sinai Hospital of Battimore	4b. City, Town, or Baltim	050	4c. County of Death N/A
Funer Directo		219–30–3040 1 M 2 M F 66 Yrs. Months	or 1 Yaar If Under 24 Hrs. Deys Hours Min.		9. Birthplace (Stata or Foreign Country) PA
/and wow		Usuel Rasidence of Decedant  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
o Mary	ctor	MD BALTIMORE BALTIMORE			1 ☐ Yes 2 💆 No
er death with the Maryand Herra 23s or 28s-f show the match political at	al Director	106. Street and Number ONE SWANHILL DRIVE	ip Code 21208	10	g. Citizen of What Country? U.S.A.
3 2 2	by Funeral	11. Merital Status  1 □ Never Merriad 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Evar in U,S. Armed Forces?  1 □ Yas 2 ☒ No If Yes, Give Yeer or Dates:  13. Was Decedent Evar in U,S. Armed Forces?  1 □ Yas 2 ☒ No If Yes, Give Yeer or Dates:	edent of Hispanic Origin? (Secity Cuban, Mexicen, Puert 2(XNo Specity:	pecify Yas or No- o Rican, etc.)	14. Race - American Indien, Bleck, White, atc.  Specify: WHITE
Maryidand ZIZIS-UUZU d 2 should be filed within 72 hours ah th and Mexal Hypiens and are are 7 ie marked other than "satural", or traumatic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highast grada completed)  Elementery/Secondary (0-12)  12  16a. Decedent's Us (Give kind of we life. DO NOT life. DO NOT HOMEMAKER)	ork dona during most of wor use ratired)	rking	6b. Kind of Business/Industry  OWN HOME
to Had dother	BeC	17. Fether's Name (First, Middle, Last)		ne (First, Middle, M	aiden Surname)
ould b Ments mrked	ToB	REUBEN CHESLER	SARAH		ZUCKER
2 shy h and is m					City or Town, State, Zip Code)
		20a Method of Disposition (N	ILL DRIVE - E		, MD 21208 0c. Location - City or Town, Stata
Pages nent of ) net: If he iry or o		Wall Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)  BETH EL MEMO		11/16/99	RANDALLSTOWN, MD
permit. Pages 1 at Department of Hear Important: if Hem: any Injury or othe	8500	21. Signature of Feneral Service Licenses 22. Name of	and Address of Fecility	SOL LEV	INSON & BROS., INC. IKESVILLE, MD 21208
aeth certificate be secuted  attending physicien end for use as the burial-transit	edical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last  Due to (or as a consequence of d.	methicillin cancer to	resista.	nt staphylococus aun
e death cert the attending	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying	ceuse given in Part I.	23b. Did tot	pacco use contribute to the cause of death?
het th datac	by Phy	Anemia		1 □ Ye	8 2□ No 3□ Probably 4☑Unknown
e lew requiras thet has been signed to ge 2 should be date	Completed t	Thrembocytopenia		24a. Wes an perform	
Pe as a	Con			1 □ Ye	s 20No 1□Yes 25No
Physician: The this certificata ral director, peg	Be	25. Was cese rafarred to medicel examiner?  1   Yas 2   No	Other	eth (Check only one	
After fune	tlon: To	1  Yas 2 No Prospiration 2  ER/Outpatient 3 I I  27. Manner of Death  28a. Date of Injury (Month, Day Year)  2  Accident investigation  2  Accident S Month	28c. Injury et Work?  1 Yes 2 No	28d. Describe ho	nce 6 □Other (Specify) w injury occurred
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, ferm, street, factor building, etc. (Specify)	ery, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, Stete)
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifiar (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurre on the best of examination and/or invastigation and manner stated.	n, in my opinion, daath occu	urred at tha tima, da	te and place, and dua to tha cause(s)
Tot Tot Com	Σ	1 11/1 000	9c. License number	29	d. Date signed (Month, Day, Year)
,0.		Jeepal Kashyap III. U.	P1320+	N/	wember 15,1999
1.0	`A = 4 = -	30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)  Sings Hospital of Baltimore 240)  31. Dete filed (Month, Dey, Year)  32. Registrer's Signature	West Belve	dere Ave	nue Baltimore, MD 2121.
Regi:	State strar	NOV 17 1999 Deneva D.	sparks		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey /3 Month Physician Susan 3:35 AH November (Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie North Arundel Hospital Anne Arundel If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral Days Hours Months 1□M 2×F -581 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits If item 27 is marked other than "natural", or items 23s or 28s-( show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10a. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 21061 U.SA Funeral quenue 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 11. Marital Status 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if fem 27 is marked other than "eny Injury or other traumatic event, tha Mananda. Elementary/Secondary (0-12) College (1-4or 5+) 12 aw 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 80 =/31e alter amar 2 19a Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Burnie Milton ametin ta 20b. Plece of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lice 22. Name and Address of Fecility functions Burne Ud 21061 se, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Ust only one cause on each line. Approximate Interval Between Onset end Death Physician Breast Corcinoma Yeurs /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): or Attending Physician: The law requires that the desth certificate be associ P.O. Box 68760, Due to (or es e consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ™ Inknown Division of VItai Records. Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 No 1 □ Yas 1 Yas 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 212 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and tiple of certified 29c. License number 29d. Dete signed (Month, Dey, Year) Nov Ouse MYSicoan 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) X/AOM 2HOU 30/ HOSP Tal d Glen Burnie M.O. 2106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 17 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amenditem 1 per phys. G781 3/1/00 yg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Marta Aquino Simon Month **Physician** MAO November /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hospital Cen | 7. Abe (In yrs. last birthday) enter Baltinore 5. Social Security Number ) Guara If Under 1 Yaar Birthplace (State or Foreign Country) Funeral 69 1 M 20XF Months Deys Hours Director Phillipine UNKNOWN 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or itema 29s or 28s-4 show other traumatic event, the Madical Examinar must be notified at Parkville Saltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A 21234 1111 Avenue uttu 0 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Bleck, White, etc. 2 should be filed within 72 hours after n and Mentel Hygiens. Is marked other than "natural", or its 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Phillipino ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 2 UNKNOWN UNKNOWN on o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Heeith an Important: if item 27 ie. any injury or other trau E.R. Beltran Timonium maryland 21093 4 (andlelight 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crametory or other plece) Dete 20c. Location - City or Town, Stata 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from State NOV. 15 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Maney Valley Mem. Gar. 1999 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Evans Chapel of memores 8800 Harford Rd teatres Baltimoreims 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner os the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760 Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed' 1 Yes 2 □ No 1 Yes 2□ No After this certificata To the Hospital or Attending Physician: "
within 24 hours eiter death.

To the Funeral Director: After this cartification outpletaly filled in by the funeral director; 8 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury et Work? 27. Manner of Deatl 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 281. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29a. Certifier

State

Registrar

29b. Signature and titlefol of

31. Date filed (Month,

Illiam

Iroh

ceuse of death (Item 23a) (Type, Print) 9000 Franklin

32. Registrar's Signature

29c. Licensa number

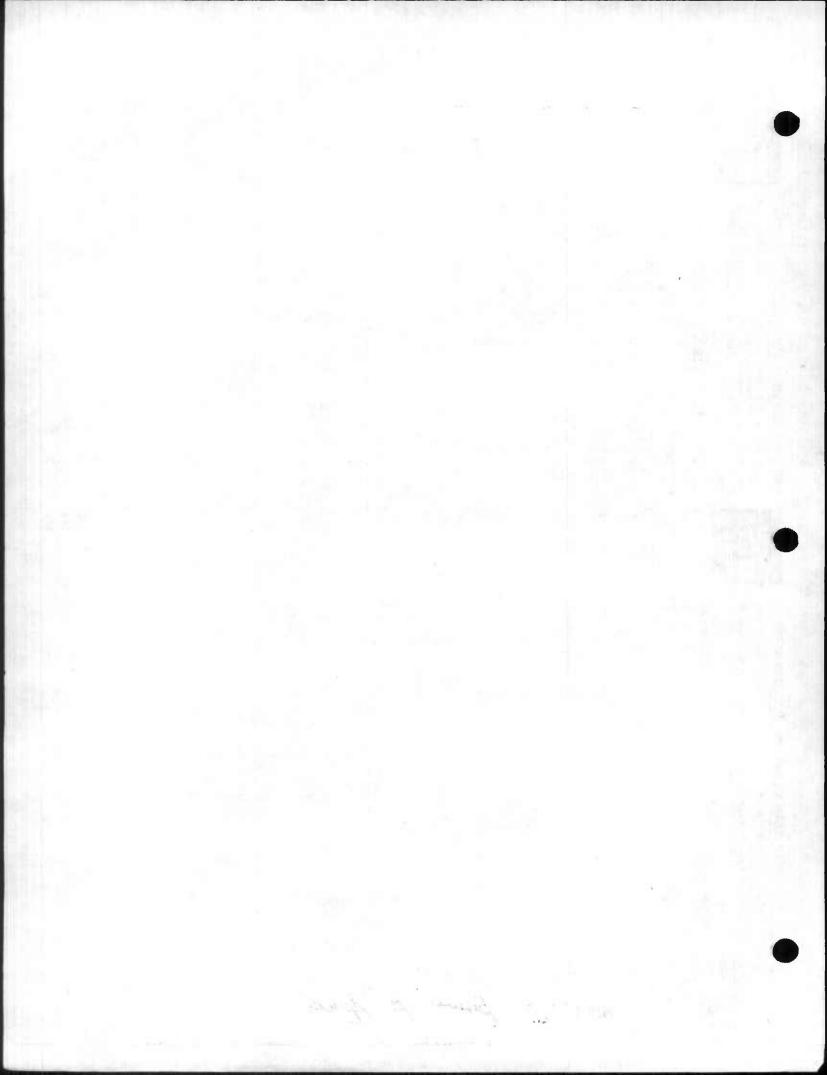
oaks

Square

Drive Baltimore,

29d. Date signed (Month, Dey, Year)

November 12, 1999



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#1perPhy,#5 perFHG778 12/28/99 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Theo! tion of Death 4c. County of Deeth Young 4e Fecility Neme (If not Institution, give street and number, 4b. City, Town, or Location of Death TENERA if Under 1 Yeer 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 214-33-4246 UNK 1 1 M 2 □ F Months Deys Hours Korea Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Perry Hall 10a. Street end Number 10f. Zip Code 10g. Citlzen of Whet Country? 11 Fox Brier Lane 21236 USA 14. Rece - Americen Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Korean 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Pharmacist Medical 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) (Unknown) (Unknown) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Sang Tae Ahn - son-in-law 11 Fox Brier Lane, Baltimore, Md. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Durial 2 Cremation 3 Removal from State 11/6/99 Meadowridge Memorial Pk. 5 Qther (Specify) 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) neumonia (accmoma Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

MD

Director

Funeral

ģ

Completed

**Funeral** 

Director

r than "natural", or items 23s or the Medical Examiner must be a

Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiens.

Baltimore, Maryland 21215-0020

The Maryla

Examiner

physician end the buriel-transit ettending pl for use es t ed by the e signed b s certificate hes b director, page 2 s funeral deeth. efter deeth 24 hours

The law requires that the deeth certificate be executed

or Attending Physician:

Hospital

Division of Vital Records, P.O. Box 68760,

25. Wes case referred to medicel exeminer?

1 Yes 2 No

27. Manner of Death

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Physician/Medicai þ Completed Be 2 Certification:

filled in by Medical To the Hosp within 24 ho To the Fune completely fi

> State Registrar

29b. Signeture end title of certifier aughte

5 Pending

investigation

6 Could not be

MD

1 DInpatient

28e. Dete of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

2 No

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

Hospital:

aryland General

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Year) NOV 1 1999

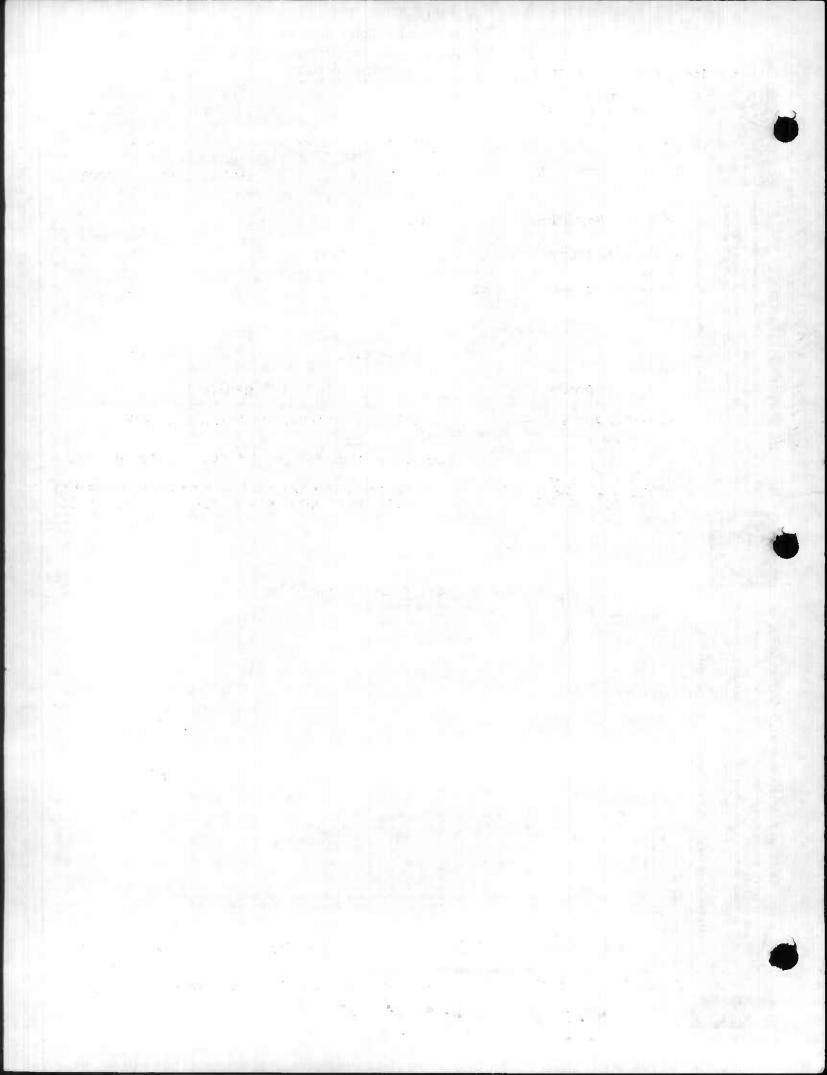
32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

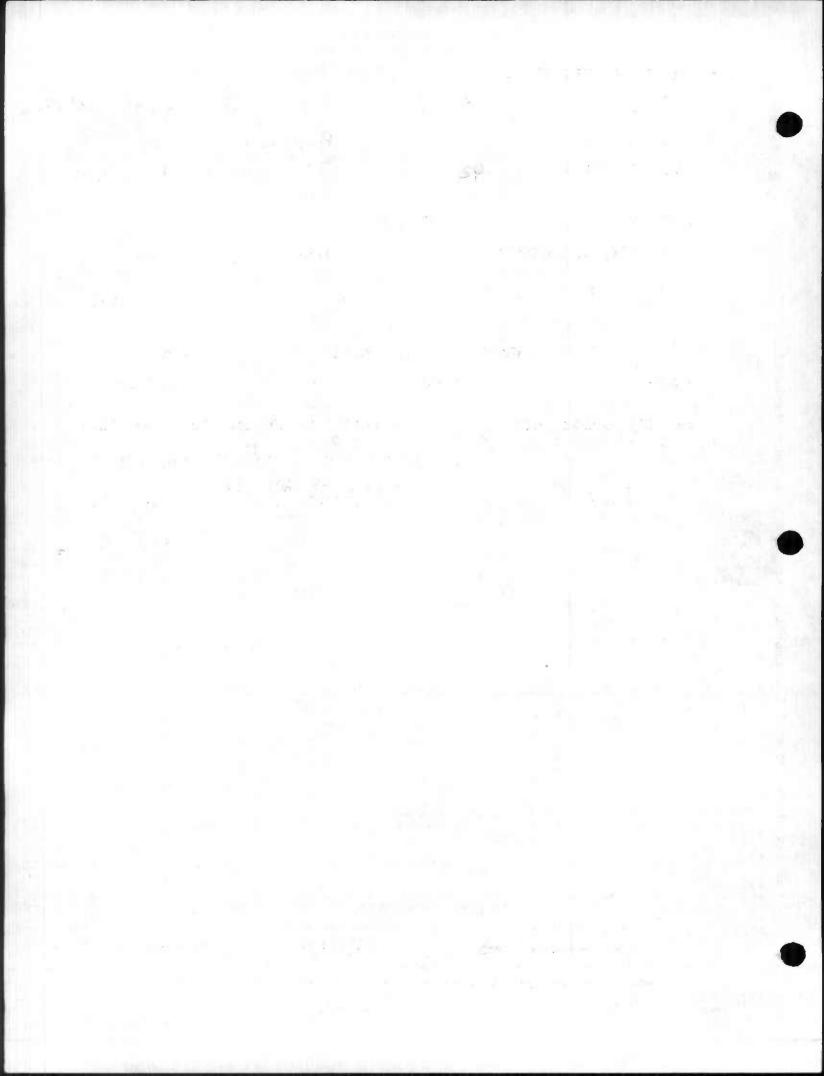
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Ame	nde	d Item#7 perFH G777 11/			te of Death	·	Reg. No.	y 3	6090	
	Physiciar /Medica		1. Decedent's Name (First, Middle, Last) George D. Singer				2. Date of De Month	Day	q q	3. Time of Deeth	
)	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo  Bathimore					N/A			
	Funeral Director		5. Social Security Number  5. Social Security Number  11  Usuel Residence of Decedent	est birthday)   If Under 1 Year   If Under 24 Hrs.   8. Days   Hours   Min.   M			9. Birthplece (State or Fore Country) MARYLAND		ece (Stete or Foreign ry) LAND		
	permit. Pages I and 2 should be filled within 72 hours efter deeth with the Maryland Department of Haalth and Mental Hygiena. I important: if flem 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Med call Exandrer must be notified at once.	ector	10e. Stete 10b. County 10c. City, Town or Location						10	Od. Inside City Limits	
			MARYLAND N/A  10e. Street and Number	BALTIMORE 10f. Zip Code					1 □XYes 2 □ No		
		ai Dir	3601 CLARKS LANE APT#522		107. 21		10g. Citizen of U.S		.ry?		
aryland 21215-0020		eted by Funeral Director	11. Marital Status  1 □ Never Merried 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ▼ No. if Yes, Give Yeer or Detes:		if Yes, specify Cuban, Mexican, Puerto		(Specify Yes or No- orto Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc. Specify: WHITE		etc.	
			15. Decedent's Edu (Specify only highest grad	ucation	16e. Decedent's Usuel Occupetion (Give kind of work done during most of work		orkina	16b. Kind of Business/Industry			
		Completed	Elementary/Secondary (0-12) +4 College (1-4or 5+) +4 YEARS		PHARMACIST			PHARMACY			
		To Be	17. Father's Neme (First, Middle, Last) MORRIS	SI	NGER	18. Mother's N MOLLIE	ame (First, Middle,		ne) OLAN		
			19e. informent's Name/Reletionship (T)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				er, City or Town, Stele, Zip Code)			
			1 X Burial 2 Cremetion 3 Removel from State Cemetery, cremetory or other piece)					20c. Location	20c. Location - City or Town, Stete		
Baltin			21. Signeture of Funerel Service Licenses  SHAAREI ZION CONG ROSEDALE BALTO. CO. MD  22. Name and Address of Facility SOL LEVINSON BROS., INC. 8900 REISTERSTOWN ROAD BALTO., MD 21208								
ı	Physician /Medical Examiner	niner	23a. Pert / Erruir the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  Immediate Ceuse (Final disease or condition resulting in deeth)  Due to (or es a consequence of):  The Charles of the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  Pack of the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  Pack of the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  Immediate Ceuse (Final disease)  But the disease or condition on the cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  Pack of the disease or condition on the cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  But the disease or condition on the cardiac or respiretory errest,  Approximate Intervel Between Onset and Deeth  ntervel Between Onset and Deeth Intervel Between Onset and Deeth Intervel Between Onset and Deeth Intervel Between Onset and Deeth Intervel Between Onset and Deeth Intervel Between Onset and Dee								
Division of Vital Records, P.O. Box	ate has been signed page 2 should be d	Completed by Physician/Medical Examiner	Couse (Disease or Injury that initiated events resulting in deeth) Lest  Due to (or es e consequence of):								
			Pert II. Other significant conditions contributing to death but not resulting in the underlying			cause given in Pert I.	23b. Did tobacco use contribute to the cause of deat				
							24e. Wes o	en eutopsy med?	com	re eutopsy findings ileble prior to opietion of ceuse eeth?	
							1 🗆 Y	es 2 No	1 🗆	Yes 2X No	
	ls certific director,	To Be	25. Wes cese referred to medical exeminer?	26. Plece of Deeth (Check only one)							
	n 24 hours efter deeth.  • Funeral Director: After bletely filled in by the fune	ledical Certification:	27. Menner of Deeth  1 Neturel 5 □ Pending	1 Impatient 2 Envoutpatient 3 DOA 4 ANursing Home				d. Describe how injury occurred			
			2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,		M 1 ☐ Yes 2 ☐ No ne, ferm, street, fectory, office 2		28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
			29e. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2. Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner steted.								
			29b. Signeture end fill discertifier  29c. License number  123 99					29d. Dete signed (Month, Dey, Year)  November 13, 1999			
	0		30. Name and address of person who co	and the same of th	Wick 700 W	40 × 5.	BULTIMULE	m) 2	1211		
	Sta	te	31. Dete filed (Month, Day, Year)	32. Rigistrer's Signat	ture A	21/1					

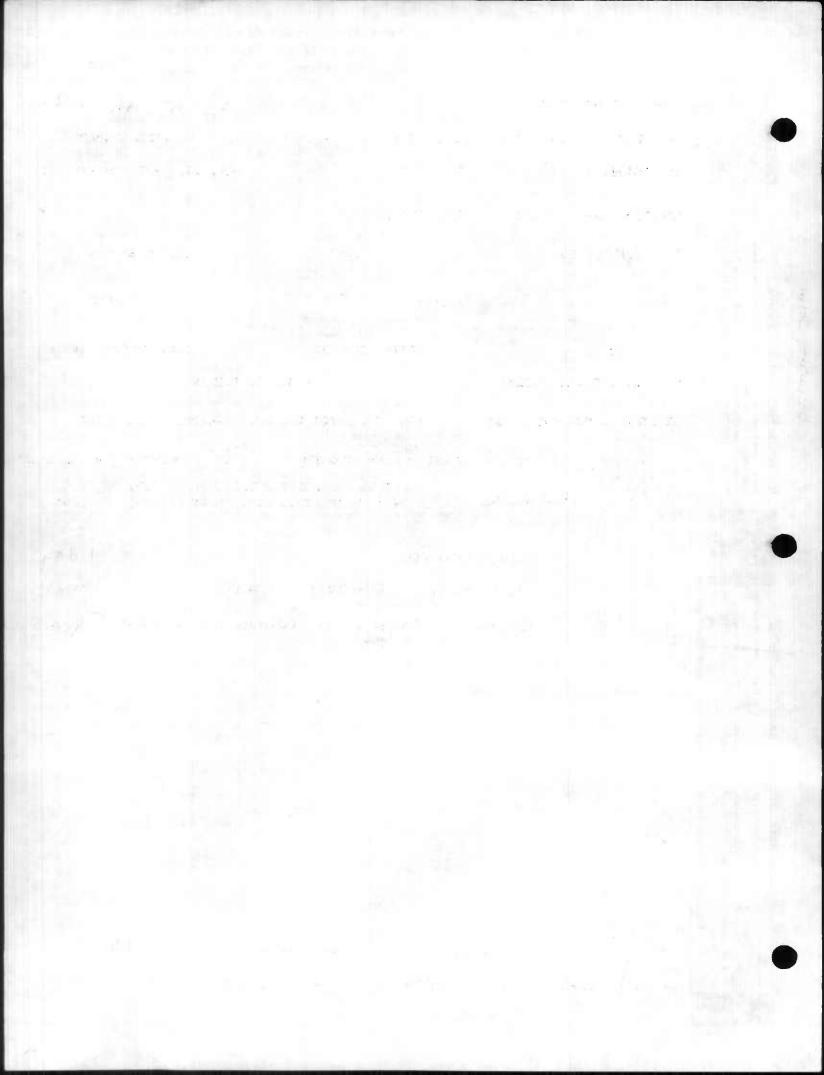


certificate be execu

P.O. Box 68760 use es ettending | ed by the e signed by t peen pege 2 hes certificete Division of Vital director. this unerel After death. or Attend efter death Director: à To the Hospital o within 24 hours eff To the Funerel Di completely filled in

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** 7:36 AM JOHN WILLIAM SCHARDT 11 1999 15 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAMMONDS LANE GENESIS ELDERCARE CENTER BROOKLYN PARK ANNE ARUNDEL If Under 24 Hrs. If Under 1 Vear 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) Funeral Months Days Hours 1X1M 2□ F 72 198-201-1004 OCT. 14, 1927 PENNSYLVANIA Director Usual Residence of Decedent the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 7 is marked other than "natural", or items 23s or 28s-f shot traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Director 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 18 GREENWOOD RD. 21061 UNITED STATES Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 72 hours efter 1 X Yes 2 No If Yas, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE If Yas, Give Year or Dates: 45-47 à 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Cotlege (1-4or 5+) Elementary/Secondary (0-12) 12 POSTAL EMPLOYEE U.S. POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middla, Last) Be Pages 1 end 2 should be nent of Health end Mental HERBERT PATRICK SCHARDT VIOLA B. PUTNAM le ma 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Relationship (Type, Print) of Health e WILLIAM L. SCHARDT / SON 1806 ST. MARGARETS RD., ANNAPOLIS, MD 21401 Date 20b. Place of Disposition (Nama of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) NOV. 17 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or phose. 4 □ Denation 5 X Other (Specify) ENTOMBMENT CEDAR HILL CEMETERY 1999 BROOKLYN PARK, MARYLAND of Funday Service Licensee 22. Nama and Address of Facility 21. Signat KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxemia Due to (or as a consequence of): Examiner Bladder CANLER Me hastatic physicien end s the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of) Polmonary Disense · Chronic Obstructive Physician/Medical that initiated events resulting in death) Last Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed 24e. Was an eutopsy performed? 2 20No 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicet examiner? Be 26. Place of Death (Chack only ona) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 40%Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. edicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D53462 MD

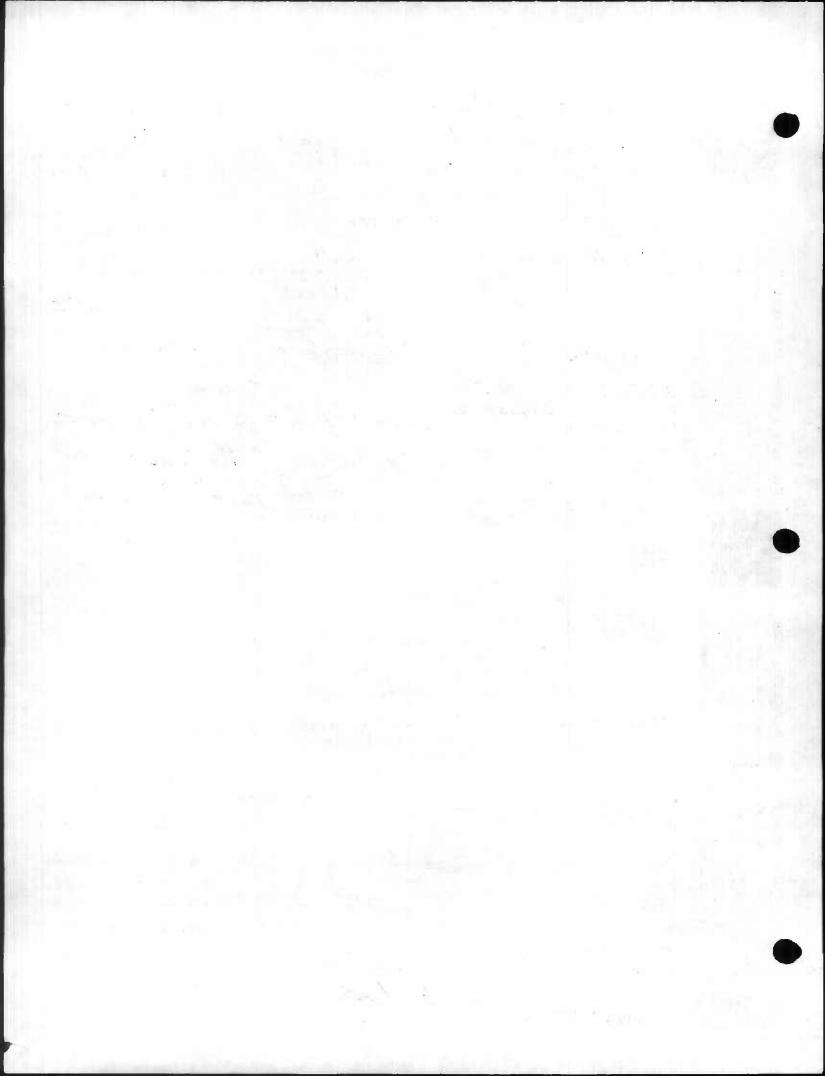
Physician /Medical Examiner 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy lindings available prior to completion of ceuse of death? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite-9 71047 31. Date liled (Mohth, Day, Year) Belair Fallston, MD 2112 ROAd 32. Registrar Signature State oaks uner 1999 Registrar



## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Re	g. No.	0.0.7.6
	Physician /Medical	1711114 1111114	2. Date of Death Month		3. Time of Death
	Examiner	4n Equility blame (If not institution, give street and number)	r Location of Death	4c. County of Death	
	Funeral Director	5. Sociel Security Number  6. Sex  7. Age (In yrs. last birthday)  Wonths Days Hours Mit  Usuel Residence of Decedent	n. (Month, Day,	Year) 9. Birth	place (Stete or Foreign ntry)
	with the Meryland a or 28a-f show the notified at	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits Yes 2 □ No
	iffer deeth with the Me r flems 23a or 28a-fa iner mark be notified Funeral Director	10e. Street end Number  10f. Zip Code  2095 ROCKROSE AVE.  2/2//	10	Dg. Citizen of What Cou	ntry?
020			Specify Yes or No- irto Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0020	ied within 72 hours it ygiene. Nor than "natural", o nt, tre Mendel Ess. Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	orking	16b. Kind of Business/In	dustry
CA	of other is avant, to Be Co	17. Father's Neme (First, Middle, Last)	ame (First, Middle, N		
2	gges 1 and 2 should be filed it of Heelin and Mentel Hyg or other traumatic avant, To Be C	19e. Informent's Neme/Reletionship (Type Print) EXH NDER 19b. Mailing Address (Street and Number of 19b. Market Place #	Rural Route Number,	City or Town, State, Zij	2/202
altimore,	Peges 1 end in ment of Heelth nent; if Item 27 ary or other tr	20e. Method of Disposition  1	7	BALTE .	own, Stete
Balt	permit. Pege Department of Important: if any injury or once.	21. Signature of Euneral Service Licensee  ARach  22. Name and Address of Fecility  SHARDA F-H.	2829 H	1D. 2/2	24
I	Physician	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardishock, or heert failure. List only one cause on each line.	ac or respiretory arre	est,	Approximate Intervel Between Onset and Death
	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)  e. End Stage Alzhein  Due to (or es e consequence of):	ner's	1	
	be executed cian end burial-trensit	Sequentially list conditions, if eny, leading to immediate		1	
687	g physicials the burner of the	Ceuse (Disease or injury that initiated events resulting in deeth) Lest  C.  Due to (or es a consequence of):			
Box	deeth c	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did to	bacco use contribute t	to the cause of death?
s, P.O.	es that the deeth cert igned by the ettendin be deteched for use by Physician/N	Depression	1 TY		obably 4 Unknown
9	The lew requires rate has been sign page 2 should be Completed by		24a. Wes as perform	ned? an	fere eutopsy findings vailable prior to ompletion of cause i death?
a B	cate h		1 □ Ye		☐ Yes 2☐ No
<b>\rightarrow</b>	this certific ral director.	25. Wes case referred to medical examiner?  1  Yes 2  No	Home 5 Reside	e) ince 6 □Other (Speci	(h/)
Division of Vital	to the hospital or Attending Physician: The low within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Comp.		7	ow injury occurred	'''
Divis	To the Hospital or Attending Property of the Funeral Director: After the completely filled in by the funeral Medical Certification:		28f. Location (St. City or Town	reet and Number or Rui n, Stete)	al Route Number,
	the Hosp nin 24 hou the Funer apletely fil		curred et the time, da	ate end plece, end due	to the cause(s)
	To within	H. D 2014	6	9d. Date signed (Month)	-99
	()	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  HEMALATA  DEVAD  Solution  31. Dete filed (Month, Day, Year)  12. Registrate's Signature  10.00	2095 Re	xKroseau	c Ballo
	State Registrar				141.71711



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dev William James NOVEMBER /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Ho spice at Mercy 7. Age (In yrs. lest birthday) | H Under 1 Year Months Days Baltmorel If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) NIA Stella Maris 5. Social Security Number 6. Sex / Birthplace (Stete or Foreign Country) **Funeral** 10 M 20 F 0525-22-612 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits worle na 23a or 28a-f short Bultmone 1 PYes 2 □ No Funeral Director N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road 4014 21515 1519 Cedare ale 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Heme 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Rece -American Indien, 11. Meritel Stetus Black, White, etc. traumatic event, the Medical Examiner 1 Never Merried 2 Married If Yes, Give Year or Dates:11/1/45-2/4/47 ò 1 ☐ Yes 2 ☐ No Specify: Blace Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail 7 2 Clerk Stop Shop & Saug Bane Pages 1 and 2 should be filed nent of Health end Mental Hygi int: if frem 27 le marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Mattie Smith on known 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 4014 Celar date nt of Health e If Item 27 Is or other tra Daphne Smith Daughter Load. bultimone, NO 21215 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Department of Important: If any Injury or n/18/99 Owings Kills Carnson Forest VA Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Foresal Service Hari 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Baltimone MD 10515 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition rasulting in death) Examiner Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): ate has been signed by the attending p page 2 should be detached for use es Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? unknown e Hospital or Attending Physicien: The 124 hours after deeth. The Funeral Director: After this certificate is bielely filled in by the funeral director, pag 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) STELIA MARIS AT MERC Be 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSpicE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Injury 28a. Date of injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Subject tell - P Accident ne 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number of City or Town, Stete) 4014 Cedarda le Road Baltimore, Mary and 4 Homicide Home Baltimore 29a. Cartifiar (Check only one) Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manuar as stated. | Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 29b. Signetyse and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Mul 4 M 30. Name and eddress of person who complated cause of deeth (Item 23a) (Type, Print)

State

**DHMH 16 Rev 6/95** 

filed within 72 hours efter

21215-0020

Baltimore, Maryland

or Attending Physicien: The lew requires that the death certificate be executed

Division of Vital Records,

31. Date filed (Month, Dey, Year) Registrar NOV 1 7 1999

DAVID

RISEBER

32. Registrar's Signeture

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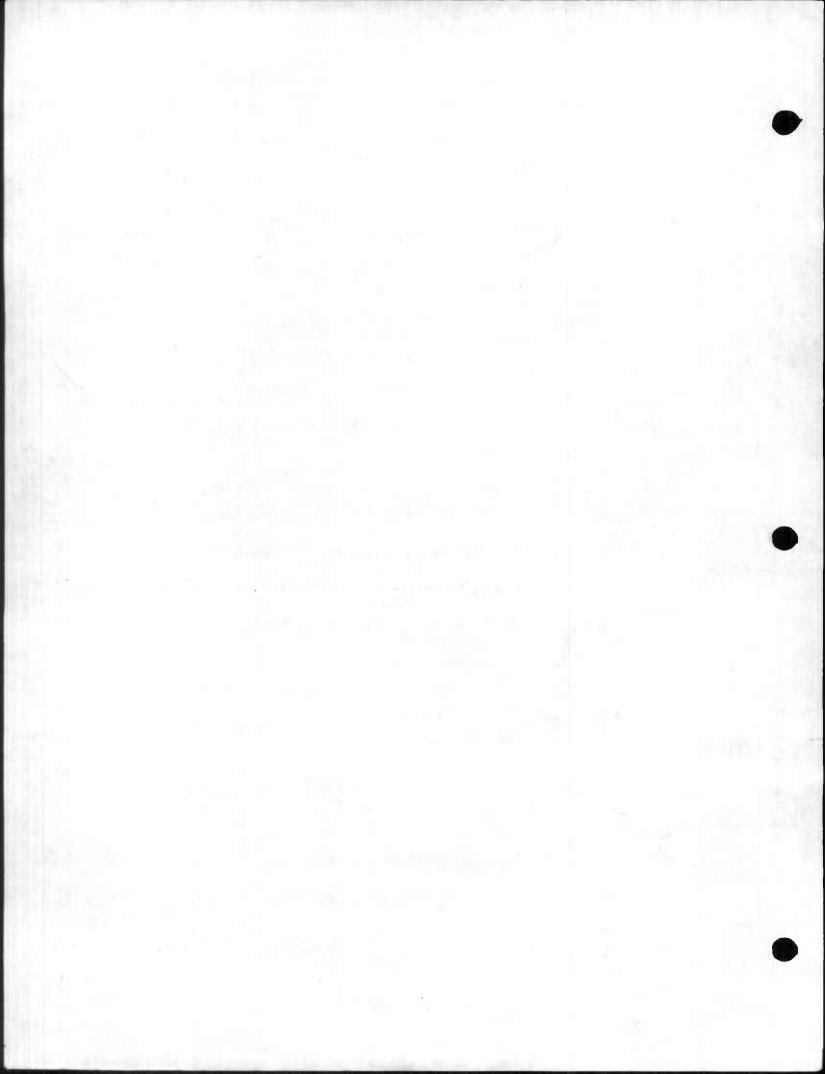
**ORIGINAL** 

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg	. No. 99	36094
				2. Date of Death Month	Day Year	3. Tima of Death
	Physici /Medi		RICHARD SCOTT	HOVEMBL		9 7:57 PM
	Examir		4a Facility Nema (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death	4c. County of Dea	th
			MORTHWEST HOSPITAL CENTER RANDALLS	TOWN	BALTI	more
	Funeral Director		5. Social Security Number  6. Sex 15-16-1374  6. Sex 1 Aga (In yrs. last birthday) 7 Yrs.  Wonths Deys Hours Min.  Usuel Residence of Decedent	8. Date of Birth Month, Day, Y	9. Bir 1922 Sol	thplace (State or Foreign ountry) LITI+ CAPOLINA
	pue A.		10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits
	with the Meryland ta or 28a-f ahow	6	MADULAND 11/A BALTIMADI	- 1	7/	1/© Yas 2 □ No
	the 1	90	MARYLAND N/A BALTIMORE  10e. Street and Number 10f. Zip Code	100	Citizen of Whet C	ountov?
	with Maria	ā	15 1		USA	
	ne 23	era	11. Marital Status   12. Was Decedant Ever in U.S.   13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Am	
5-0020	us after deeth with the Menyler II', or itams 23a or 28a-f show	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 3 Widowed 4 Divorced  12. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Forces) 1 Yes, Give Yaar or Datas:	Rican, etc.)	Specify:	te, etc.
Ö	72 hou		15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business	/Industry
215	hin 7	Completed	(Specify only highest grada completed)  [Give kind of work dona during most of working life. DO NOT use retired)  [Give kind of work dona during most of working life. DO NOT use retired)	9		
2	d wit	EO	12+GRADE CAR INSPECTS	ORIF	RAILRO	AND COMPANY
P	vert by	Be	17. Fether's Neme (First, Middle, Last)  18. Mother's Neme	(First, Middle, Ma	iden Sumame)	
/la	Vid b	To	WILLIAM HENRY SCOTT SR ANGR	ONIE	SAL	NDERS
any	ons :		19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural			
Σ	elth 27 i		ATLANTA SCOTT (WIFE) 15 LIBERTY PLACE RO.  20e. Mathod of Disposition 20b. Place of Disposition (Name of Disposition)	AD, APTE	BALTIMO	RE, MD. 21244
ore	of He item	-		Dete 20	c. Location - City or	Town, State
Ē	ortant: Page entment o		18 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Othar (Specify)  PARKWOOD CEMETERY :   -	18-99 V	BAITIMA	OF MARVI AND
altimor	mit.		21. Signature of Funaral Service Licensee  22. Nama end Address of Fecility BRO	To To	Taule 0	al Hames
m	SOE S		SI 40 N. FULTON	DUE B	FUNER	AL HOME
	Physician		23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or show, or heart failure. List only one cause on each line.			Approximete Interval Between Onset end Death
d	/Medical		Immediate Ceuse (Finel disease or condition resulting in death)  e. A CUTE MYOLARDIAL /NFA	ACTION	S	1 HOUR
	Examiner		resulting in deeth)  Due to (or es e consequence of):			
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	be executed sician and buriel-transit	E	D:			/
Ó	exe an a	Ä	Sequentielly list conditions, if any, leeding to immediate cause. Enter Undertying Ceuse (Disease or Injury C. DIABETES MELLITUS			YEARS
68760,	ificate be exact g physician and as the buriel-tra	edical Examiner	Couse (Disease of Injury that initiated events rasulting In death) Lest Dua to (or as a consequence of):			
		ě.				
Õ	attending	and a	d			1
. E	dea ded fo	Sici	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobe	cco use contribut	e to the cause of death?
S, P.O	v requiras that the death cer been signed by the attendin should be detached for use	y Phy	CHRONIC RENAL FAILURE	1 🗆 Yes	2 No 3 F	Probably Thiknown
Division of Vital Records, P.O. Box	₹ 20 00	Completed by Physician/N		24a. Wes an e		Were eutopsy findings eveilable prior to completion of cause of death?
H	The law ate hes b page 2 s	E		1 ☐ Yes	2 2 No	1 Yes 2 No
a	tifica tor, p	BeC	25. Wes case referred to medical 26. Place of Deeth	(Check only one)		
>	yalcius s cer	To	examinar? Hospitel:		pe 6 ☐Other (Spe	ecity)
o uo	iding Phy ith. : After thi			8d. Describe how		
Divis	To the Hospital or Attending Physician: The la within 24 hours after deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page?	Certification:	2D Suiside 6D Could not be	Bf. Location (Stre City or Town,		Rural Routa Number,
	e Hospit n 24 hour e Funera	edlcai (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end of a manner stated.			
	Within To th	×	29b. Signeture and title of cartifier 29c. License number	290	. Date signed (Mon	th, Day, Year)
			04758)	N	DUEMBER	13_1955
	00	1				
	CY)		ROBERT FINE. NO 5401 OLD LOURT ROAD 1	ZANDALLS	TOWN M	D 21133
	Sta	te_	30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)  ROBERT FINE. NO 5401 OLD COURT ROAD  31. Dete filed (Month, Day, Year)  32. Registrar's Signature y		•	
	Registr		1 1000 have			



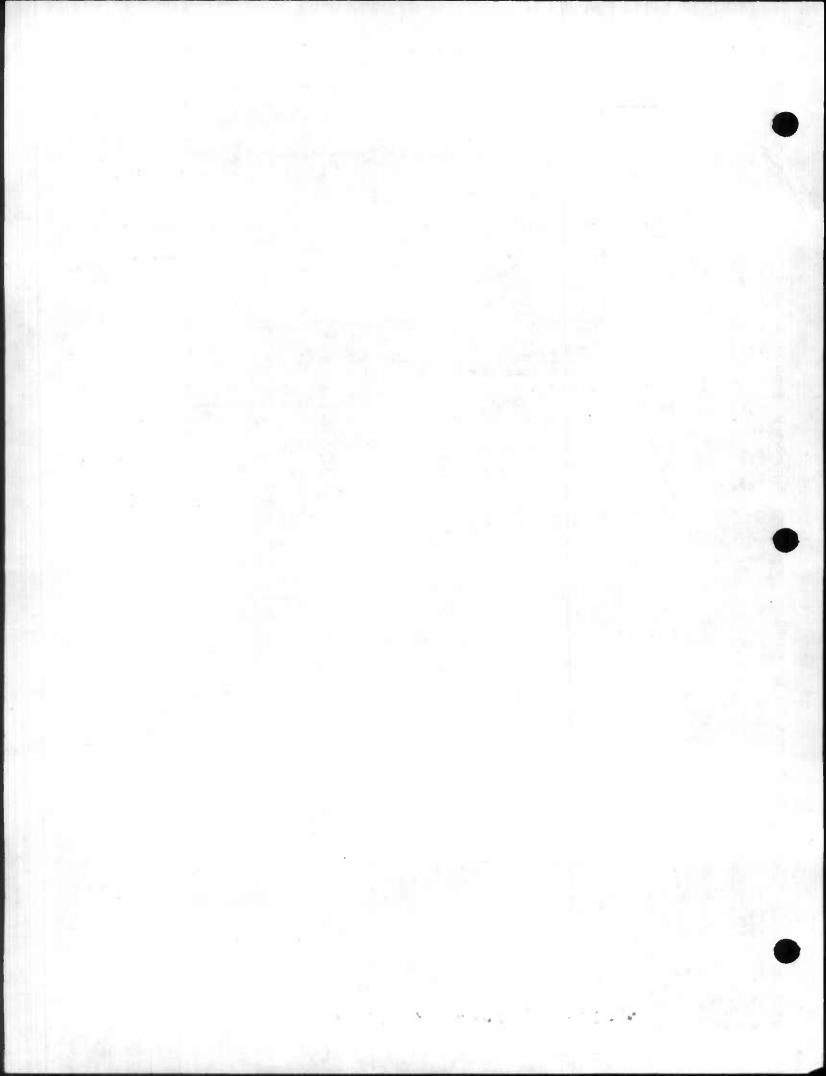
State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) NOV 1 7 1999

ennis

hutemo 111 PENN STREET BALTIMORE, MARYLAND 21201 32. Registrar's Signatura



	790-510	Please	Type or Pri	nt in Black in	delible In	k. Assure	All Cop	pies Ar	e Legi	ble.	
	99-274		State of M	aryland / Dep			d Menta	Hygie	ne	0 7	TO NAME
asp	GERARD	SPANN		Ce	rtificate o	f Death		Reg.	No.		00476
	Physician /Medical	1. Decedent's Name (First, Middle, Li Gelard Wilb	ur Spa	nn			2. Date	of Death	Day13	<b>19</b> 99	3. Time of Death 12:08 A
	Examiner	4a Facility Name (If not institution, git JOHNS HOPKINS HO				4b. City, Town BALTIN		Death	4c. County	of Death	
	Funeral Director	5. Social Security Number 6. 914-86-5661		96 (In yrs. last birthday) Prs.	Months Day		Hrs. 8. Date Min. //2	of Birth ott, Day/Ye		9. Birthple Count	ace (State or Foreign
deeth with the Marviend	tined at	Usual Residence of Decedent  10a. State  10b. County  NA		10c. City, Town or La			•	,		10	d. Inside City Limits  1/☑ Yes 2 ☐ No
the state of the s	23a or 28a-fa ust be notified all Director	10a. Street and Number 5956 Daywalt	- AUR # K 21206 U						Citizen of V	en of What Country?	
	in, or he barrior by Fur	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 K If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Co		? (Specify Yes verto Rican, e	or No-		e - America ck, White, e	
21215-0020	- B	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  Collegé (1-4or	16a. Dece (Give life. 5+)	dent's Usual Occ kind of work dor DO NOT use reti	expation ne during most of ired)	working	160	CP	usiness/Indi	ustry
Maryland 2	Be very	17. Father's Name (First, Middle, Last	0			BALK.	Name (First, I	SPAN.	n		
- 5	Health Pm 27 ther tr	19a. Informant's Name/Relationship Patricia Spar 20a. Method of Disposition		20b. Place of Dispo	sition (Name of	AH AVE	.1	Balti	More	State, Zip (	21206
Baltimore	ant: If ury or	1 Surial 2 Cremation 3 E 4 Dogation 5 Other (Speci	fy)	Mf. Zio		retery	11/17/	99 3	altin	lore,	Marylano
Balt	Depa impo eny il paca	21. Signalum of Funeral Service Lice	roma	the	2. Name and Add	. Carol	Betts ine s	ture	Him	lone ore, t	ud. 21213
	nysician	23a. Part Finter the disease, or cen shock or heart failure. List only	A A	0			rdiac or respire	itory arrest,		1	Approximate Interval Between Onset and Death
	Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	Nul.	tiple Gu	nshot l	Vounds				1	

To the Nospital or Attending Physician: The law requires that the death certificate be executiful 24 hours after death.

To the Puneral Director: After this certificate has been signed by the attending physician and Completely filed in by the Intensity Intensity and Completely filed in by the Intensity Intensity and Completely filed in by the Intensity Intensity and Intensity and Intensity and Intensity

signed by the a d be detached b

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by

Due to (or as a consequence of): Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed?

1 Nes 2 No 1 Pres 2 No 26. Place of Death (Check only one)

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending 11-12-99 2332p M 1C
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) subject shot 1 Yes 2 No investigation 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) lock Oliver Street 3 ☐ Suicide 4 Afomicide

Baltimore, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999 29c. License number O.C.M.E

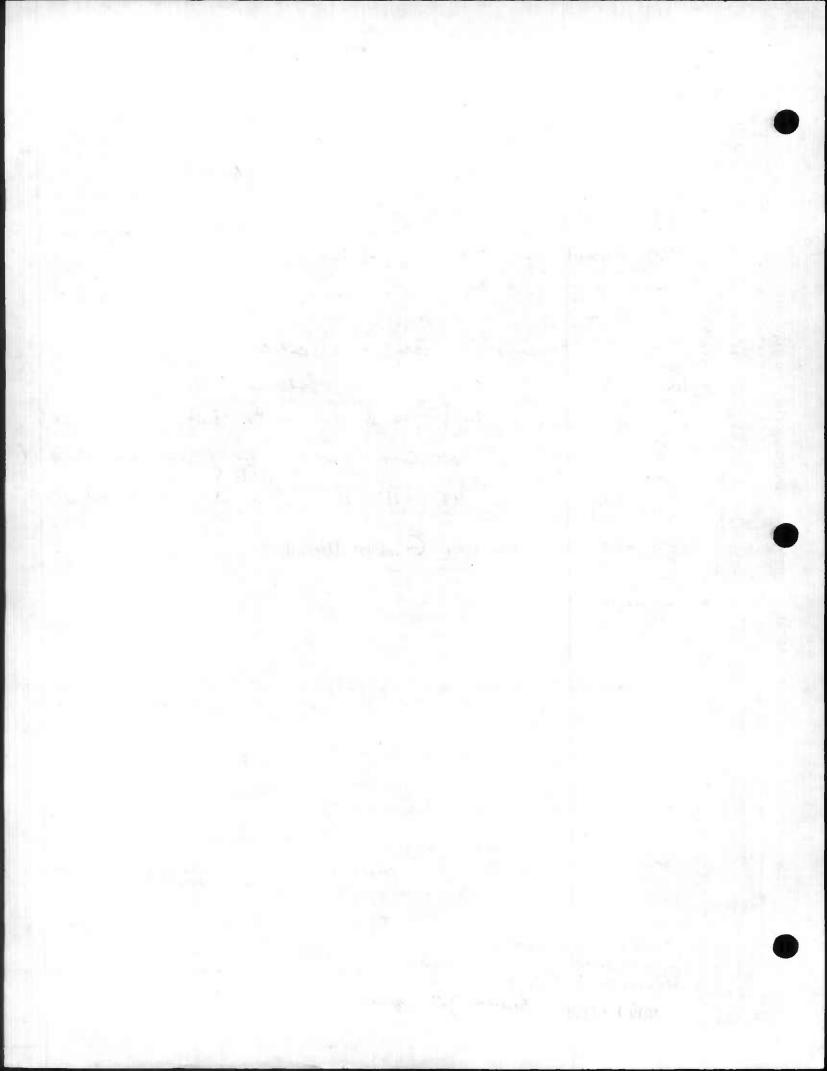
the blance and eddress of person who completed cause of death (flem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year) NOV 1 7 1999 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #20b & 20c PER FH G777 11/19/99 AH Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dey Month Year **Physician** Trodgen Nettie Nov. 15, 99 10:20am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore Lorien Frankford Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sax Funeral Days Months 1□ M 25 F Hours 215-18-3992 85 Director 08-14-14 SC Usual Rasidence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD KCXYas 2 No NA Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 5009 Frankford Avenue 238 21206 USA Funeral Berns 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces?
1 ☐ Yas 2 ☐ No 14. Race - American Indian, Black, Whita, etc. an "natural", or itse Medical Examiner 72 hours after 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black ģ 3□Widowed 4□Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) filed within 7 Hygiene. other than "n NA College (1-4or 5+) Elemantary/Secondary (0-12) 8 Th Grade Cafteria Worker Company 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be fit iment of Health and Mental H lant: If frem 27 is marked oth Be Apt#202 John Woodard Hanna Jenkins 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Intormant's Name/Ralationship (Type, Print) Martha 1508 Harford Avenue Baltimore, Maryland Britton 20b. Place of Disposition (Nama of WOODL AWN comatary, crematory or other place) CEMETERY 20a. Mathod of Disposition 20c. Location - City or Town, Stata Department of Important: If It any injury or o once. WOODLAWN, MD 1 Burial 2 Cramation 3 Ramoval from Stata Voshell Mem. Gardens 11-19-99 4 ☐ Donation 5 ☐ Othar (Specify) Dundalk, MD 22. Nama and Address of Facility Baltimore, Maryland 21202 21. Signatura of Funaral Sarvice Licensaa WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not writer the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata rval Beb Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical NEMMONTA DATES **Examiner** Dua to (or as a consequence of) Physician/Medical Examine YRS ATOVANCED DE SHELL BUS physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated evants Dua to (or as a consequence of): 68760 8 Dua to (or as a consequance of): rasulting in death) Last 88 Box esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown BILATIMAL BLA'S; CVA 2 24b. Ware autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy > G-TUSE; AveniA - OSTEUP GROSIS performed?

The law requires thet Records, hes Division of Vital

edical Certification: To sidi

Be Completed

25. Was casa rafarred to medical

I or Attending Physician: after deeth. I Director: Affi Hospital

To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 5 Panding invastigation 2 Accidant

3 Sulcide

29a, Certifian

6 Could not be datarmined 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar MO

28a. Data of tnjury (Month, Day Year)

29c. License number 1941791

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year) 11-16-99

28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)

nuces

1 Tyes 2 No

21117

1 Yas 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

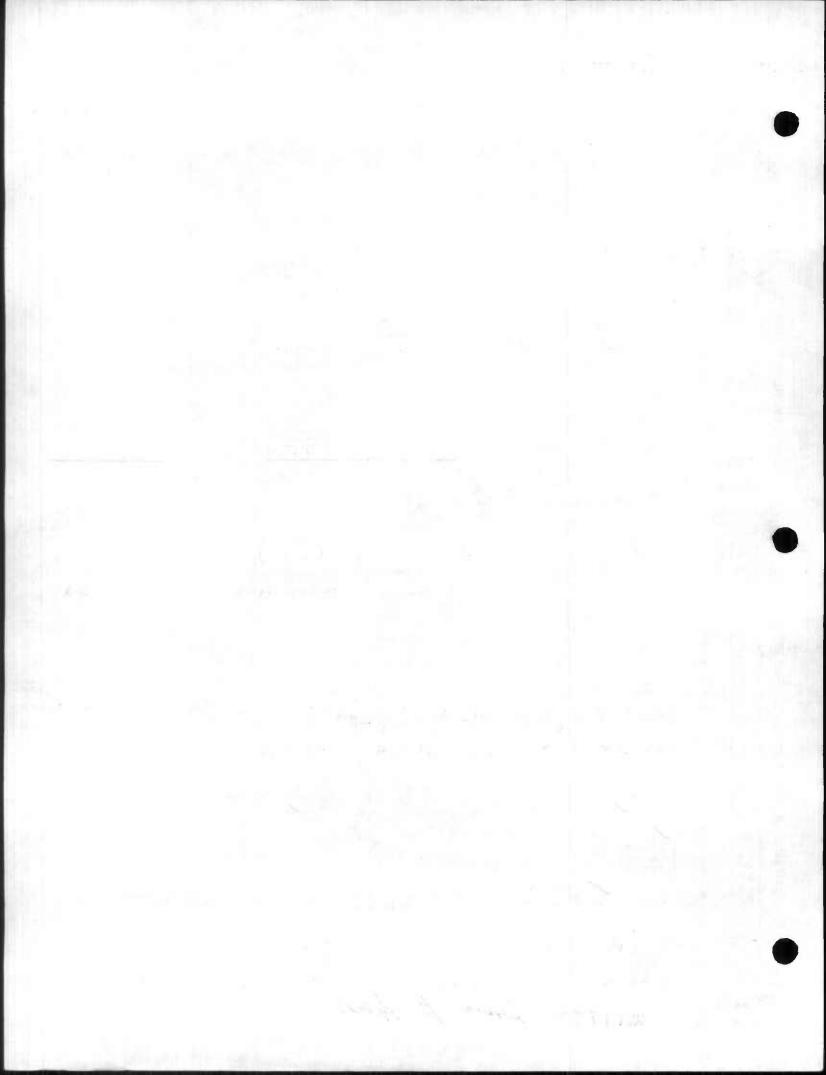
Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

30. Nama and addrass of person who complated causa ot death (Item 23a) (Type, Print) GITTER, NO. ZIGROSSIMMOS INMMOON

31. Data tiled (Month, Day, Year) NOV 1 7 1999 32. Registrar's Signature

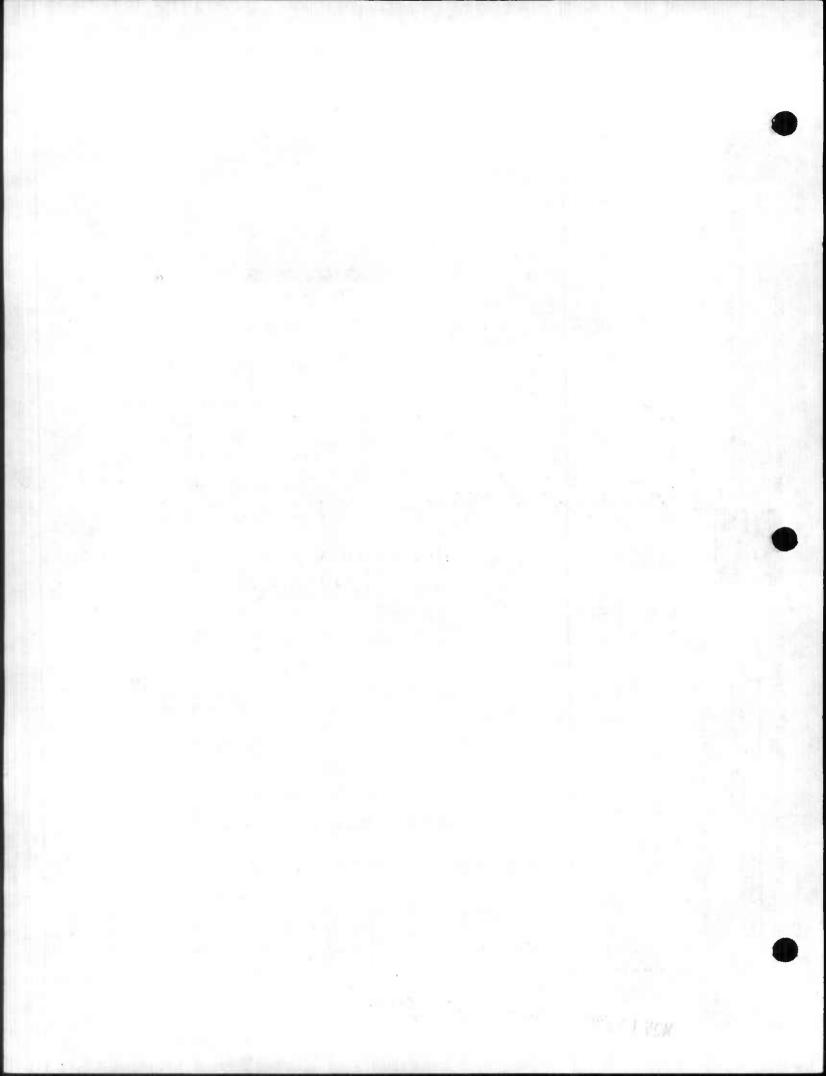
28a. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify)

OR # 336 GWWGS



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)  Marcus Cooper JOHNS HOPKINIS HOSPITAL 600 North Wolfe Street, Bultimore, MD 21387  State 31. Dete filed (Month, Day, Year)  32. Registrar's Signeture Sports		ding In.	tion	1 ☑Neturel 5 ☐ Pending	(Month, Day	Year)	Injury			200. Describe	now anjury occur	ieu	
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30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)  Marcus Cooper JOHNS HOPKINIS HOSPITAL 600 North Wolfe Street, Bultimore, MD 21387  State 31. Dete filed (Month, Day, Year)  32. Registrar's Signeture Sports		Hospit 24 hour Funera stely fill		(Check only 2   Medical Exar	niner: On the basis of	examination :	ge, death occum and/or investigati	ed at the time, ion, in my opin	date and place ion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	and due to the	d. cause(s)
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** Lewis Junior Turner 0707 AM 1999 Novemen /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Union Memorial Hospital If Undar 1 Yaar | if Undar 24 Hrs. 8. Data of Birth (Month, Pay, Year) 06-18-18 Birthplaca (Stata or Foraign Country) 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) **Funeral** 1 Q M 2 □ F Months Days Hours VA 81 Yrs 226-14-1381 Director Usual Rasidence of Decedant permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mantal Hygiene. Intropretari: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified and once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits X Yas 2 No Baltimore Director MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 21213 1403 Kenhill Avenue Funerai 12. Was Dacadant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Construction Co. Construction NA 2nd. Grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Turner Ernest Harden Lellia 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1403 Kenhill Avenue Baltimore, MD. 21213 Lillie Turner&Lucille Lewis 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Baltimore Cemetery 11-18-99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Baltimore, Maryland 21202 21. Signatura of Funaral Sarvica Licansas WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that could be death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath Physician metastases Non Small 60 /Medical Immediata Causa (Final with disaasa or conditior rasulting in daath) bone **Examiner** Dua to (or as a consaquance of) Examiner attanding physician and for usa as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohecco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown signed by þ 8 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? Completed complation of cause of daath? paga 2 has 1 Yas 2₽0 1 ☐ Yas 2 ☐ don cartificata 25. Was casa ratarrad to medical axaminar? Be 26. Placa of Daath (Chack only ona) Hospital: 1 Inpatiant Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) 10 1 ☐ Yas P No 2 ER/Outpatient 3 DOA this funaral 27. Magnar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b Time of 28c. Injury at Work? Aftar t Certification: 5 Panding invastigation Attanding aftar death. 1 Yas 2 No 2 ☐ Accident tha 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 3 4 Homicida 0 24 hours Hospital Medicai Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. within 2 ş, 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 020396 November MI

bath Ravan Bhil Ba Ho

State Registrar Davis

31. Data filad (Month, Day Year)

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

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De Oz. Hegistrar's Signatura

Lewis Turner

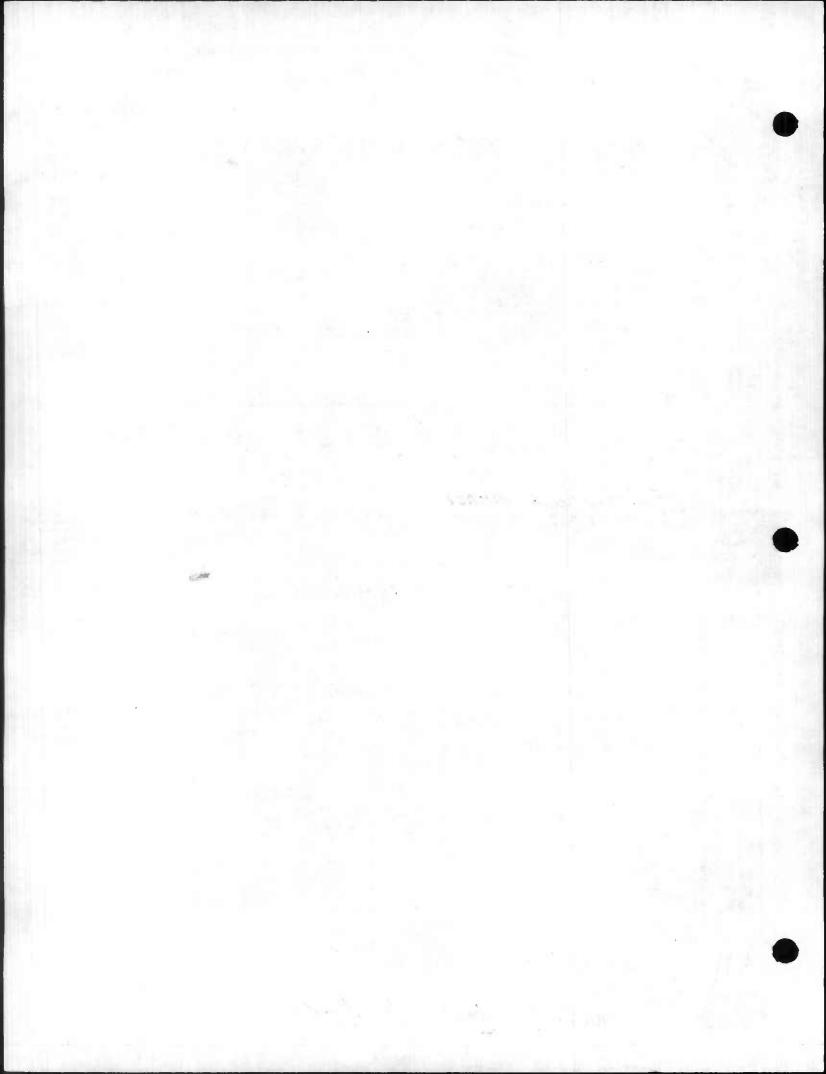
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Division of Vital Records, P.O. Box 68760,

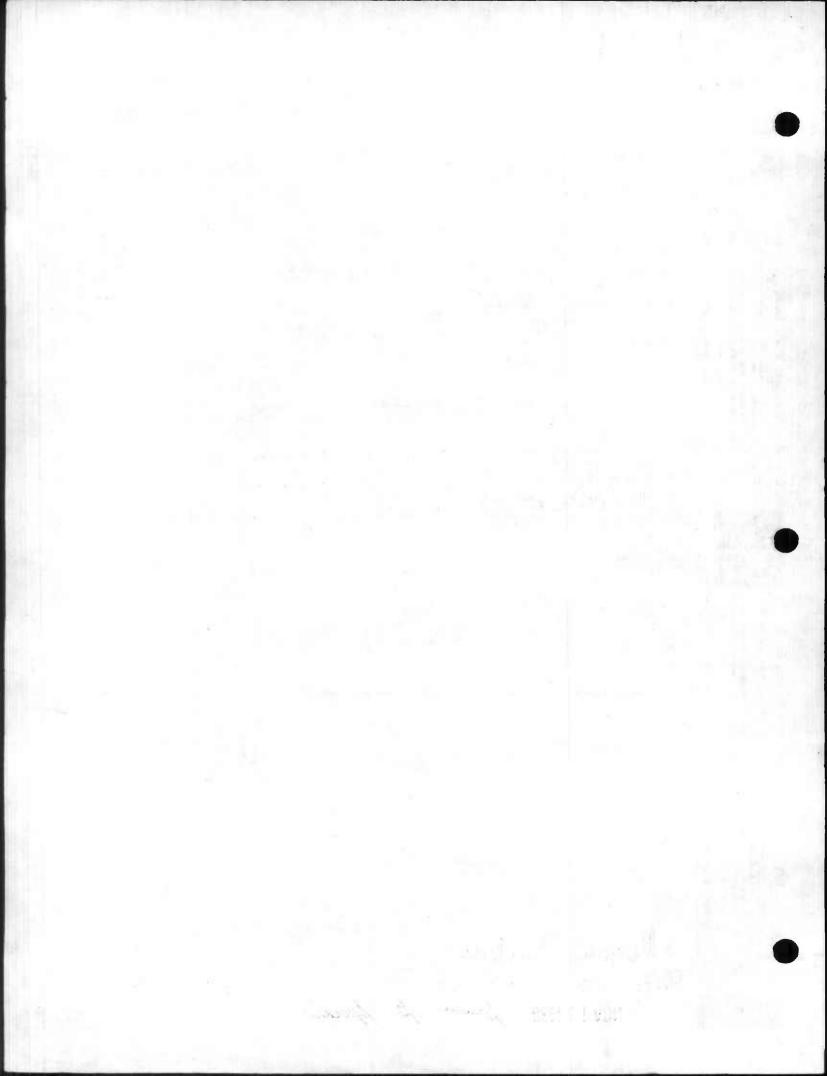
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Cen	tificate of	Death	Re	g. No.	30100
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Physician /Medical	Woodrow Wilson Talki	ngton				NOVERB	4 -1 / / 1	99 4.37 P.M.
Examiner	4e Facility Name (If not institution, give street as	nd number)			4b. City, Town, or I	Location of Deeth	4c. County of	Death
	FRANKLIN SOUALR	HOSPITAL	CEN	TRR	ROSE	PACE	BA	LTIPORK
Funeral	5. Sociel Security Number 6. Sex	7. Age (In yrs. la	st birthdey) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year) 9.	Birthplece (State or Foreign Country)
Director	Usuel Residence of Decedent	85	118.			SEPT. 6,	1914	West Virginia
Du A	10a. Stete 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
2 should be filed within 72 hours after death with the Maryland of Manual Hygiene.  In marked other than "natural", or forms 23s or 28s-f show surmatic event, the Marical Exercities must be notified at To Be Completed by Funeral Director	MD Baltimore	Dune	dalk					1 ☐ Yes 2 📉 No
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and Ide	Elementery/Secondery (0-12) Colli	ege (1-4or 5+)	-	O NOT use retired	d)		0- 1	
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Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", any Injury or other traumatic event, the Medical East and Injury or other traumatic event, the Medical East and Injury or other Traumatic To Be Completed by	Joseph Talkingto	n				ne (First, Middle, M Bice	www. Juneme)	
d Men marke	19a. Informent's Neme/Relationship (Type, Prin		10h Mailine	n Addross (Street	-	ıral Route Number,	City of Town Ste	ate. Zin Code)
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Heelth mm 27 other tr	20a. Method of Disposition	20b. Pia	ace of Dispos	ition (Name of		Date 2	Oc. Location - Cit	y or Town, Stete
nt: If Itan	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel 4 ☐ Donation 5 ☐ Other (Specify)	from State Mea	metery, crem dowrid	ne Memor	ial Park	11/18/99	Flkride	ie. Md.
ortan Injur	21. Signeture of Funeral Service Licensee	1100		Name end Addre			LIKITUS	, , , , , , , , , , , , , , , , , , ,
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	1 110000	100257				vd., Elkr		21075 Approximate
	Part1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line.	DO HOL BILLE	i the mode of dyn	ig, soon es carolat	or respiretory one	31,	Interval Between Onset and Death
hysician /Medical	Immediate Ceuse (Finel	= 0000						211 11 00
xaminer	diseese or condition resulting in death)	EPSIS	es e consequ					24 Hours
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ian a	if eny, leading to immediate cause. Enter Underlying							
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rand d	1 162 55 140		R/Outpatient 28b. Time of	3LI DOA	4 LI Nursing F	lome 5 Reside		
After fune	1 Natural 5 Pending 2 Accident Investigation	(Month, Dey Year)	Injury		k? Yes 2 □ No			
fica	3 Suicide 6 Could not be	Plece of tnjury - At hon		et, fectory, office				or Rural Route Number,
rs after death.  al Director: After tied in by the funera  Certification:	4 Homicide	building, etc. (Specify)				City or Town	, Stete)	
Sal C	29a. Certifier (Certifying Physician: T							
within 24 mays after death.  To the Function of Attention of After this certificate has been signed by the attending physician compliency filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Medical	(Check only one) 2 Medicat Examiner: On and	the basis of examination manner stated.	on and/or inve	estigation, in my o	pinion, death occu	rred at the time, da	ite and placa, and	I due to the cause(s)
W September	29b. Signature end title of certifier			29c. Licens	e number	29	d. Dete signed (/	Month, Dey, Year)
1/	7/10 nonous			04	15789		11/14	199.
WIN	30. Name end address of person who completed	cause of death (Item :	23a) (Type, P	Print)				
11.1	DR. WILPUR ROBS.		FRAL	KLIP S	QUALK	OR B.	ALTO, 1	10 2/237
· State		32. Registrar's Signatu	ire /	loo	1/21			
Registrar	NOV 1 7 1999	Deper	- /	apout	100			



State Registrar

32. Registrar's Signatura



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Cei	rtifica	te of	Death			Reg. No.		UU	106
	Diam'r.		1. Decedent's Neme (First, Middle, La	st)						2	. Date of De	ath Dev	Year	3. Tim	a of Death
L	Physici /Medi		MARGARET CLAU	DIA TAYLO	OR					N	OVEME			6:	50am
	Examir		4a Fecility Neme (If not institution, giv	a street and number)					4b. City, To	own, or Loca	tion of Death	4c. Count	y of Deeth		
			3125 ABEL AVE.							IMORE			/A		
	Funeral		Social Security Number     6. S	ex 7. Age □M:21⊠CF	e (In yrs. las		If Und Months	er 1 Year s Days	If Under Hours	Min.	Month, Da	th v, Year)	9. Birthp	leca (Ste	ata or Foraign
	Director		220-68-3182	LIM ZELF	44	Yrs.				0	4/30/	1955	MARY	<i>I</i> LAN	D
	Pur &		Usuet Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							Od Insid	e City Limits
	aho	5	MD N/A			BALT		DE					1.		res 2 □ No
	the A	Director	10e. Street and Number			DALI	-	ip Code				10a. Citizen of	What Cour	tn.2	
	With the same	ō	3125 ABEL AVE				101. 2	•	218			USA	What Court	tty i	
	the safe	era	11. Merital Status	12. Was Decedent I	Ever in ILS	13 \	Was Dec			iain? (Sneci	fv Yes or No		ce - Americ	an Indier	1.
21215-0020	72 hours after death with the Maryland natural, or Hems 23s or 28s-f show picel Examiner must be notified at	by Funeral	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:					an, Mexicar Specify:		fy Yes or No can, etc.)	Specia	eck, White,		
0	n 72 hours "natural",	P	15. Decedent's Ed			16a. Deced	ient's Us	ual Occup	pation			16b. Kind of 8			
21	C	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT	use retire	d) mos	st of working					
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Pu	tal Hygi d other	Be	17. Fether's Nama (First, Middla, Last)									Maiden Sumer	m <i>e)</i>		
Maryland	Men	2	GEORGE MEEHAN						MARG	SARET	J. 1	TAYLOR			
a	2000		19a. Informant's Name/Relationship (									er, City or Town			
	D = 7.2		RICHARD D. ADA	MS (COUS	-				STURE	E LAN	T	EVERNA			
Baltimore,	- 40		20a. Method of Disposition 1		CON	ce of Dispo netery, cren RKWO(	netory or	ame of other pla	ce)	11/1	6/99	BALTO			
Balt	pemit. Paga Department o Important: if I any Injury or bhos.		21. Signeture of Funerel Service Licer	SOO MAN TO THE		HE	ENRY	W.		KINS		IS CO.	212.		
	_	$\Box$	23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plications that ceused	the death.									Approxi	mate Between
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7	/Medical		Immediate Cause (Final disease or condition	Rec Ove	1.00	Tall	Ine							449	Bhus
1	Examiner		resulting in death)	* KESDIYA	Due to for e	s a conseq	lneuce o	f):				1			1
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	rificate be asscuted ng physician and es the burial-transit	Examiner	Sequentially list conditions,		Due to (or e				143110		1			W I	10.1 17.3
90	ye ax	9	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury										1		
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Or	been si	Completed										an eutopsy med?	ev.	ailable pr	rior to
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ō	Ø 00 0	2	1 Yes X2 No		ent 2 E			JUA				dence 6 □Ot		y)	
	uner uner	on	27. Manner of Death XIX Neturel 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury		28c. Inju Wo			d. Describe I	how injury occu	rred		
Division	Attending r death. ector: Atte by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2						
₹	or Att	Certification:	4 Homicide determined	28e. Place of Inju building, etc		e, ferm, str	eet, facto	ory, office		28	f. Location (S City or Tox	Street and Num vn, State)	ber or Rure	il Route f	vum <i>ber</i> ,
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	To the Heapital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi complately filled in by the funeral	edical	29a. Certifier X1X Certifying Phrone) 2 Medical Exam	ysician: To the best on hiner: On the basis of	examination	edge, death n and/or im	occurre restigation	d at the ti	me, date an opinion, dea	nd place, en ath occurred	d due to the lat the time,	cause(s) and m date end place	enner es si , end due to	leted. the cau	se(s)
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	, ,		30. Name and address of person who				•								
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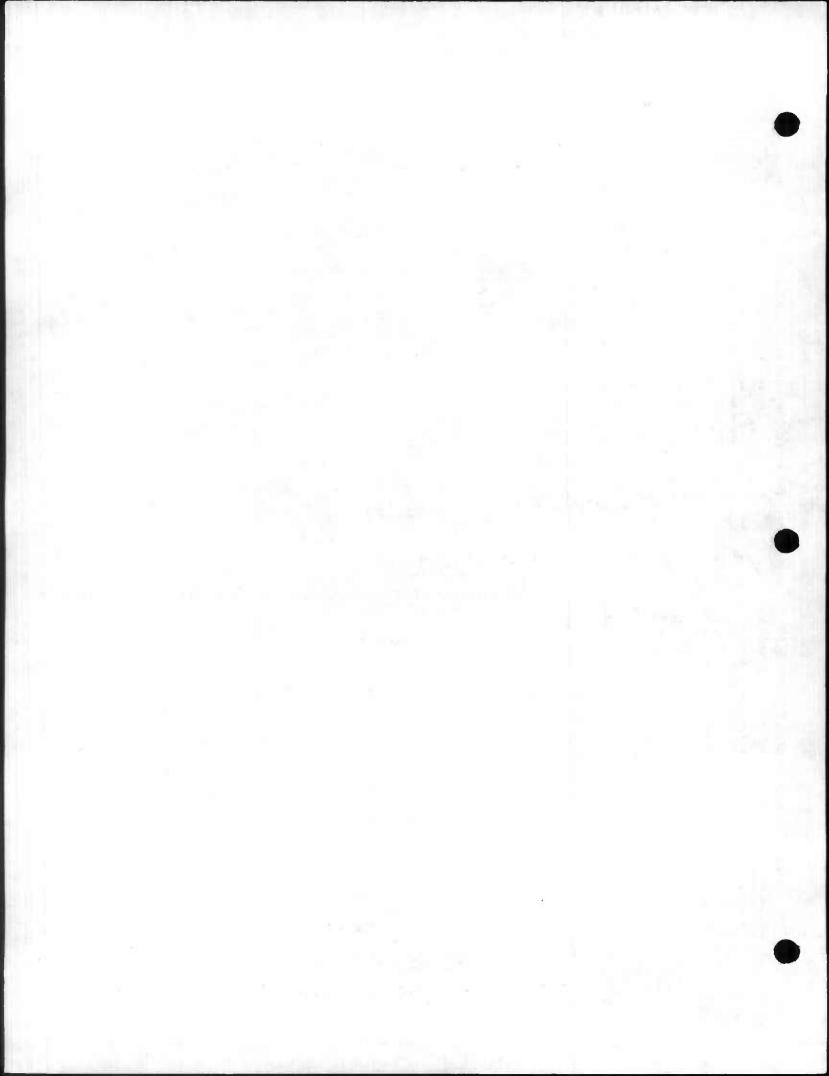
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**ORIGINAL** 



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **GERSH** VAYNER 11:45 41 November 12, 1999 4b. City, Town, or Location of Deeth 4a Facility Nema (If not institution, give street end number) 4c. County of Deeth Sinai Hospital Baltimore Baltimore 8. Dete of Birth 1.0-13-1904 if Under 1 Yeer if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplaca (Stete or Foraign 10 M 2□ F Months Deys Hours BRICHAN, MOLDOVA 95 219-35-5801 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No N/A MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2434 WEST BELVEDERE AVENUE 21215 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ≥ ÛXNo If Yes, Give Yeer or Detes: 14. Rece - American Indian, Was Decedent of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify: 3 XWidowed 4 ☐ Divorced WHITE 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS BAKER BAKERY 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middla, Last) VAYNER FLEXER HANNAH MOSHA 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 439 DOE MEADOW DRIVE OWINGS MILLS, MD 21117 MR. GLEN SIDILNIKOV -GRANDSON 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Ramovel from Stete 4 Donation 5 Other (Specify) 11/14/1999 BALTIMORE, MARYLAND BALTIMORE HEBREW CONG. -21. Signature of Funeral Service Licenses 22. Name end Address of Fecilit SOL LEVINSON BROS. 8900 REISTERSTOWN ROAD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of) Due to (or as e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 4th and 5th metatavsal gangrene, Amputation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings evellable prior to completion of ceusa of death? 24a. Wes en eutopsy performed? Diabetes Mellitus, Dysphagia, Dementia Peripheral Vascular Disease, Sacral Decubit

Physician /Medical Examiner

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cartificate

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or Attending Physician: effer death. Director: After this cartifica

24 hours Hospital

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Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

Completed

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Certification:

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**Physician** 

/Medical

10a State

Examiner

**Funeral** 

Director

r 28a-f show

Department of Health end Mental Hygiena. important: If Itam 27 is marked other than "natural", or Itams 23a or any Injury or other traumatic event, the Medical Examiner must be a

Pages 1 end 2 should be filed within nent of Health end Mental Hygiena. int: if Itam 27 is merked other than '

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Known as Gersh Vayner,

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

Pert II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was cese referred to medical exeminer?

1 Yes 2 No

Hospital:

28a. Dete of Injury (Month, Dey Year)

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Place of Injury - At home, ferm, street, factory, office building, efc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signeture and title of ceptifier

NOV 17

5 Pending investigation

6 Could not be determined

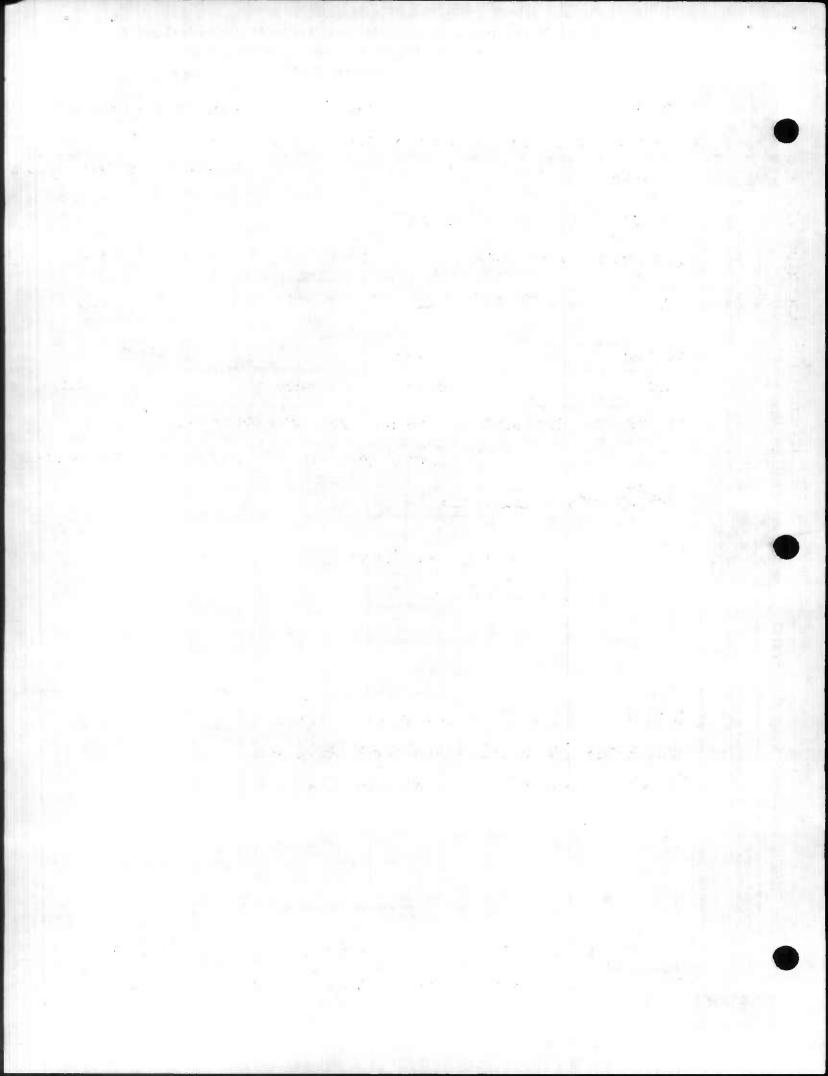
29c. License number RES 0000 29d. Dete signed (Month, Day, Year)

MD 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

1999

Baltimore, MD W. Belvedere Nelson Ave. 32. Registrar's Signatura 31. Dete filed (Month. Dey, Year)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey Month Yaar **Physician** MOVEMBER 13 1999 3:12PM VANLANDINGHAM GLADVS /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMONE してているこの スケースケー If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 20F 217-26-4286 Director APRIL 10,1916 MAR Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be flied within 72 hours after death with the Merylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show with jury or other traumatic avent, the Medical Examinat must be notified at page. 10d. Inside City Limits 1 ¥ Yes 2 No NIA Director MARYLAND log. Citizen of What Country? 10e. Street and Number 80 E 2 / 2 / 5

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) AVENUE EQUOIA USA 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tary/Secondary (0-12) College (1-4or 5+) OWN HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) 8 HARLES WHITEHURST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NYOUNG 3411 MIKE On (Name of Dete 20c. Location - City or Town, Stete GARRISON GRANDSON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State GARRISON FOREST CEME. 11-19-99 OWINGS MILLS, MD. 4.PSDonation 5 Other (Specify) TOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIHORE, MD. 21217

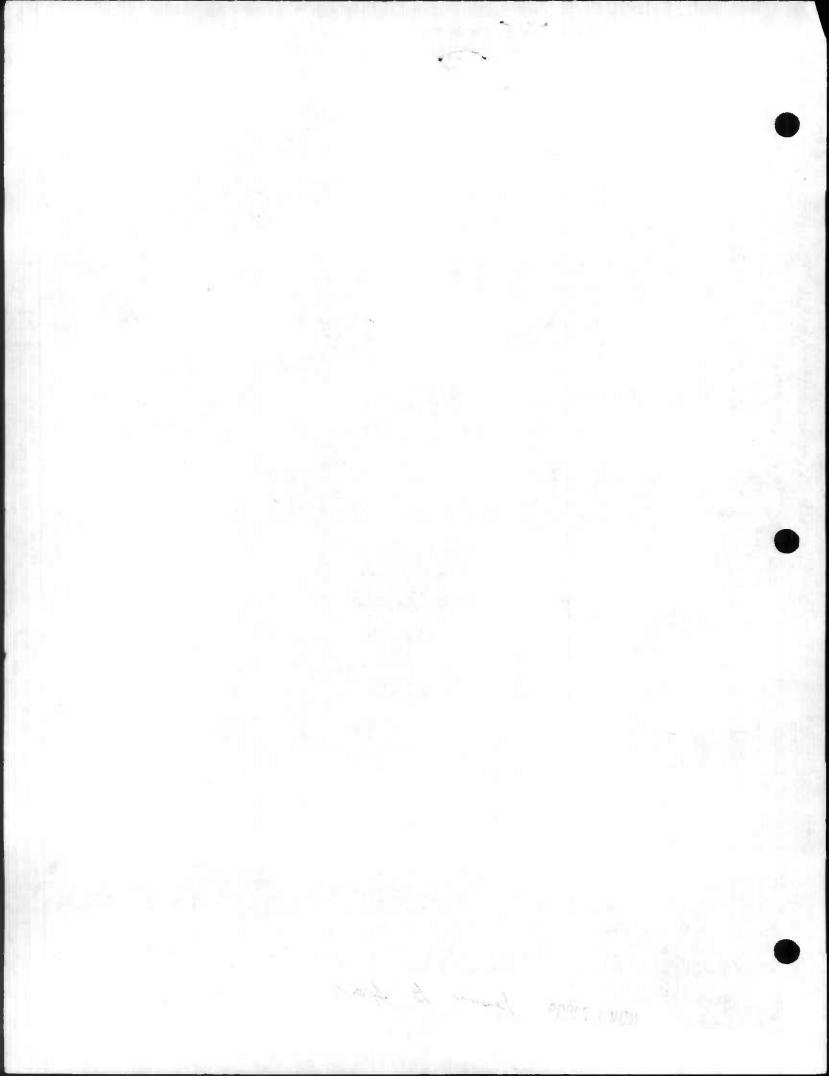
23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspirating arrast,

Approximate

Approximate Physician /Medical Immediate Cause (Final DIFUMOPIA disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner CHNONIC WENER FRICUME physicien and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): DIARETES Box 68760. MEllity Physician/Medical Due to (or as e consequence of): signed by the eld be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy Completed Yes 2 No 1 ☐ Yes 2 No certificata Division of Vital funaral director, 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Department 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 計 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Hospital or Attending P
 Ahours after death.
 Funerel Director: After it 1√ZNatural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. To the Hose within 24 ho To the Functional Completely is (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 12 1499 RI RES OGO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIS Edward BALtimore SIMAI 32 Registed's Signatury 31. Date filed (Month, Day, Year) NOV 1 7 1999

DHMH 16 Rev 6/95

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 0415 vonne Wad Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth University Medicine Baltimore O Mary and Dage (Inyud. lest birthdey) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 20 F 212 - 44-2085 Usuai Residence of Decedent Deys Hours Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Pres 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10RE 12. Was Decedent Ever in U,S. Armed Forces 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Reca - American Indien. Bleck, White, etc. 1 Never Married 2 ☐ Married Specify Lucan 1 Yes 2 No Specify: 4 Divorced 3 Widowed american 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) EVER WOKKEI 10 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) owell genea 19a Informant's Name/Reletionship (Type, Print) daughter 19b. Mailing Address (Street end Number or Refail Route Number, City or Town, Stete, Zip Code) 20b. Pleca of Disposition (Neme of cametery, cremetory or other placa) BALTIMORE, MS 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Mt. ZION 11/19/99 Lansdowne, MD 4 ☐ Donetion 5 ☐ Other (Specify)

**Physician** /Medical Examiner

Examiner buriel-transit end physician

**Physician** 

· /Medical

Examiner

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Completed

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**Funeral** 

Director

important: If itam 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be not that at

Department of Health and Mentel Hygiene. mportant: If item 27 is marked other than "natural;

Pages 1 and 2 should be filed within 72 hours efter death

T. Name: YVONUE

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After this certificate

or Attending Physician:

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To the within 2

Division of Vital Records, P.O.

Physician/Medical Completed by Be Certification: To

Immediete Ceuse (Final disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last

21. Signeture of Funerel Service Licenses

28a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying/such as cardiac or respiretory shock, or heert failure. List only one pause on each line. Bleedinntrol Ganial Due to (or es e consequenca of): pentons on

(or es e consequence of) se izures

Due to (or as e consequence of)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

11/13/901

24e. Wes en eutopsy performed?

St

ulmo/

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

M121217

nonth

1543

Immh

Approximate Intervel Between Onset end Deeth

1□ Yes 2 No

1 Yes 2 Ho

25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menney of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation Injury

1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

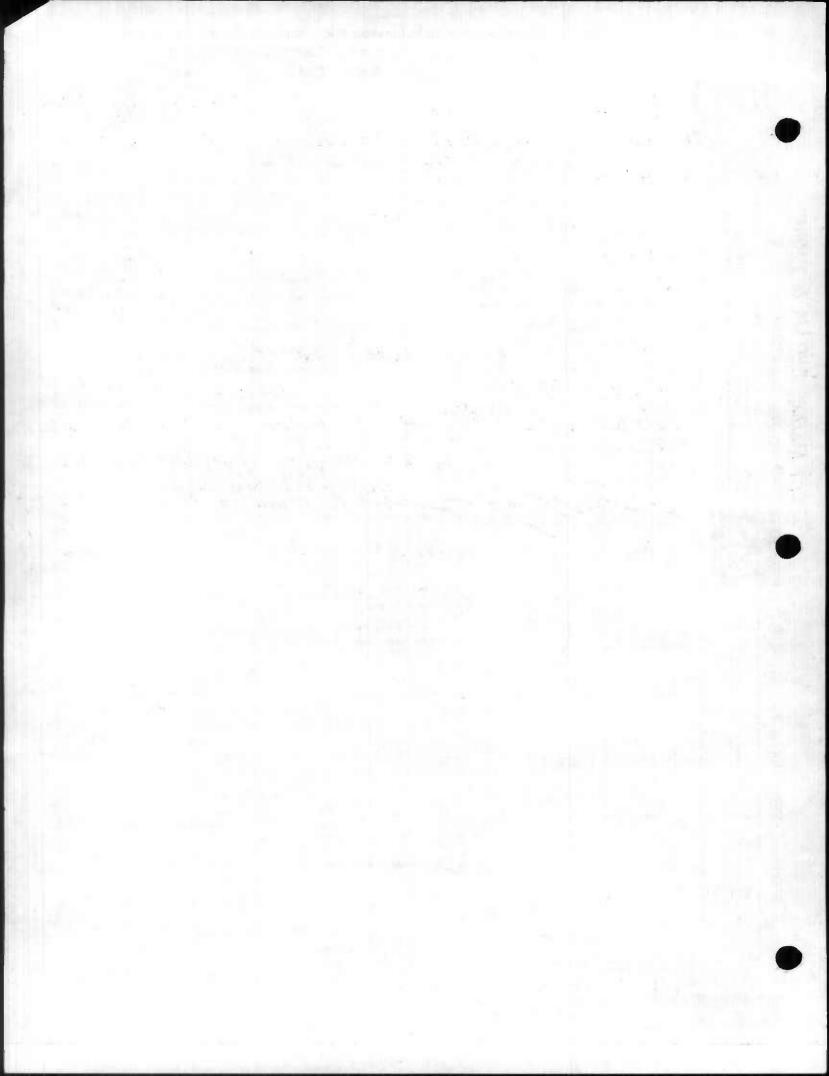
611 south charles St Balhina MDZKSO Deater mallal Onter

D 3041941

State Registrar

Medicai

NOV 17 32. Registrer's Signature



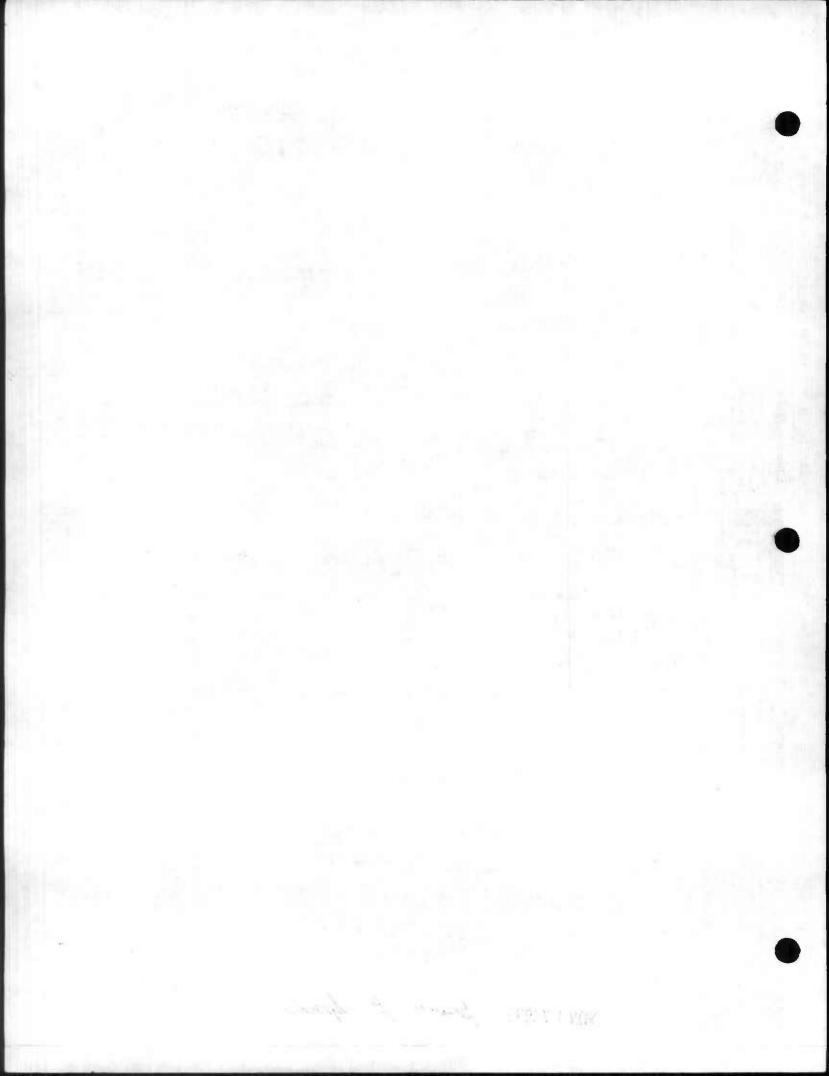
## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Reg	. No.	30100
		Decedent's Name (First, Middle, Last)				2. Dete of Deeth Month	Dey Year	3. Time of Death
	Physician /Medical	John J. Will	JJr.			Novembe	n 13 1999	2:37 PM
	Examiner	4a Facility Name (If not institution, give street and n	number)		4b. City, Town, or Lo		4c. County of Deat	
1		FRANKLIN SAWARG	HOSPITAL	CENTER	Rose	DALE	BACTI	rant
1	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last t	oirthday) If Under 1 Year		8. Dete of Birth (Month, Dey, Yo	9. Birti	nplece (Stete or Foreign
L	Director	Usual Residence of Decedent	76	Yrs. Months Days	Hours Min.	worth, bey, to	923 ma	ayland
	ylano Maria	10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	or 28e-f et be nout ed	MD Baltimo	re Par	-Kville			0	1 ☐ Yes 2 ☐ Ño
	23a or 3	2709 Fifth A	venue	10f. Zip Code	234	109	. Citizen of What Co	A.
21215-0020	2 should be filled within 72 hours effer deeth with the Meryland and Mantal Hyglans. Is marked other than "natural", or items 28 or 28s-f show reumatic event, the Medical Exemine must be notified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced   If Yes, 0	2 □ No Sive	13. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
5-0	ed within 72 ho yglene. The fred and and a fred a	15. Decedent's Education (Specify only highest grade completed		a. Decedent's Usual Occup (Give kind of work done			b. Kind of Business/I	ndustry
21	ug . u	Elementary/Secondary (0-12) College	(1-4or 5+)	life. DO NOT use retired	d)		NIII'S T	)oies
	y en a	12 -		OWNER			70 (113 )	24.19
Pu	do do the the the the the the the the the the	17. Father's Name (First, Middle, Last)			18. Mother's Neme	(First, Middle, Mei	iden Sumeme)	
la	Ment Ment Price To To I	John J. Willi	Sr.		BETT	na Bie	emiller	
Maryian	and the	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Street	end Number or Run	al Route Number, C	city or Town, Stete, 2	ip Code)
Σ	s 1 and 2 should be filled within Health and Mantal Hyglens. Item 27 is marked other than other traumatic event, the Mantal To Be Comp	Mrs. John Will, Ir-5	5000 Se 3	1709 FIFTH	Avenue	Parku	rille , ma	injland 1274
ore.	ges 1 and t of Health if Item 27 or other ti	20a. Method of Disposition	20b. Place	of Disposition (Neme of ery, cremetory or other plea	ce)	Date 20	c. Location - City or	
Baltimor	Peges nert of h int: If he iry or of	1 Uffurial 2 Cremetion 3 Removal from 4 Donation 5 Other (Specify)	n State	Klawn	N	0V.171	Baltima	e, mayland
=	Semit. Peg Separtment mportant: I any injury o	21. Signature of Funeral Service Licensee		22. Name end Addre	ess of Fecility	10,100	- 1 F Im 6	manei
B	Depenti Depenti Importa eny inju			83	on Mar	Good Ri	sad	
		Mealner Lac	n	VE	oo Har	reima	miand	Approximate
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition		otic Coron		1		Intervel Between Onset end Death
		resulting in death)		e consequence of):				1
	n end iel-transit	b						
	deeth certificate be executed estending physicien and of for use as the bunet-transit sician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or es	consequence of):				
68760,	olen burie	Cause (Disease or injury						
87	licete be physicians the bu	that initiated events resulting in death) Last	Due to (or es e	consequence of):				
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Box	eth ce ettendi for use							
	of the deeth of dby the ettend eteched for us Physician/	Part II. Other significant conditions contributing to	death but not resulting	in the underlying cause give	ven in Pert I.	23b. Did tobs	cco use contribute	to the cause of death?
P.0	requires that the desent signed by the hould be deteched the better by Physical by Physica					1 🗆 Yes	2 No 3 P	obably 4 Unknown
ú	2 58 6							
Pro	been signature should t	140				24a. Wes en e		Vere eutopsy findings eveilable prior to
Records,								completion of cause of deeth?
	The law ate has page 2					1 ☐ Yes	212No	TYes 20 No
Vital	certificate rector, per	25. Was case referred to medical			26 Place of Dont	n (Check only one)		
5		examiner? Hospitat	Inpatient 2 PERVO	Outpatient 3 DOA Oth	ner-		e 6 ☐Other (Spec	-16-1
o	Physical distriction of the Trible					28d. Describe how		жуј
O	eeth. or: After th the funeral cation:	in the state of th	e of Injury onth, Day Year) 28b	Time of 28c. Injury Wo	rk? Yes 2 No			
Division	505× =	3 Suicide 6 Could not be	ce of Injury - At home	ferm, street, factory, office		28f. Location (Stree	et and Number or Ru	ral Route Number
$\frac{2}{0}$	or At after of Direction by	4 Homicide determined 286. Plate	ding, etc. (Specify)	ionii, stroot, taotory, omoo		City or Town, S		
-		20a Cartifiar 15 Cartifician Physician To the	a book of my book do	an almost annument of the si-				-4-4-4
	医耳氏菌 完	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and ma	basis of examination e	re, deem occurred at the til and/or investigation, in my o	ne, date end plece, ppinion, death occurr	ed et the time, dete	end place, end due	to the cause(s)
	# : # o	29b. Signature and title of certifier	nner stated.	29c. Licens	te number	204	. Date signed (Monti	New Years
	H 200	D 11	101.	1-		290	. Date signed (WORK	i, vay, rearj
,	7///	majord	L. Wing	MMO	45568		11/16/99	
	11/11	30. Name and address of person who completed car		) (Type, Print)	un Rd	0 00 4	,	
	1.10	BRADFORD L. EBRIGH	T	1524 Bela	ur Kd	Balt, M	0 2123	6
	State		Registrar's Signeture	~ A li	acks/			
	Registrar	NOV 1 7 1999	Mener	~ 19	1000			

DHMH 16 Rev 6/95

WILL JOHN JULIUS



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State Registrar NOV 1 7

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32. Registrar's Signatura

J. Chute, mo

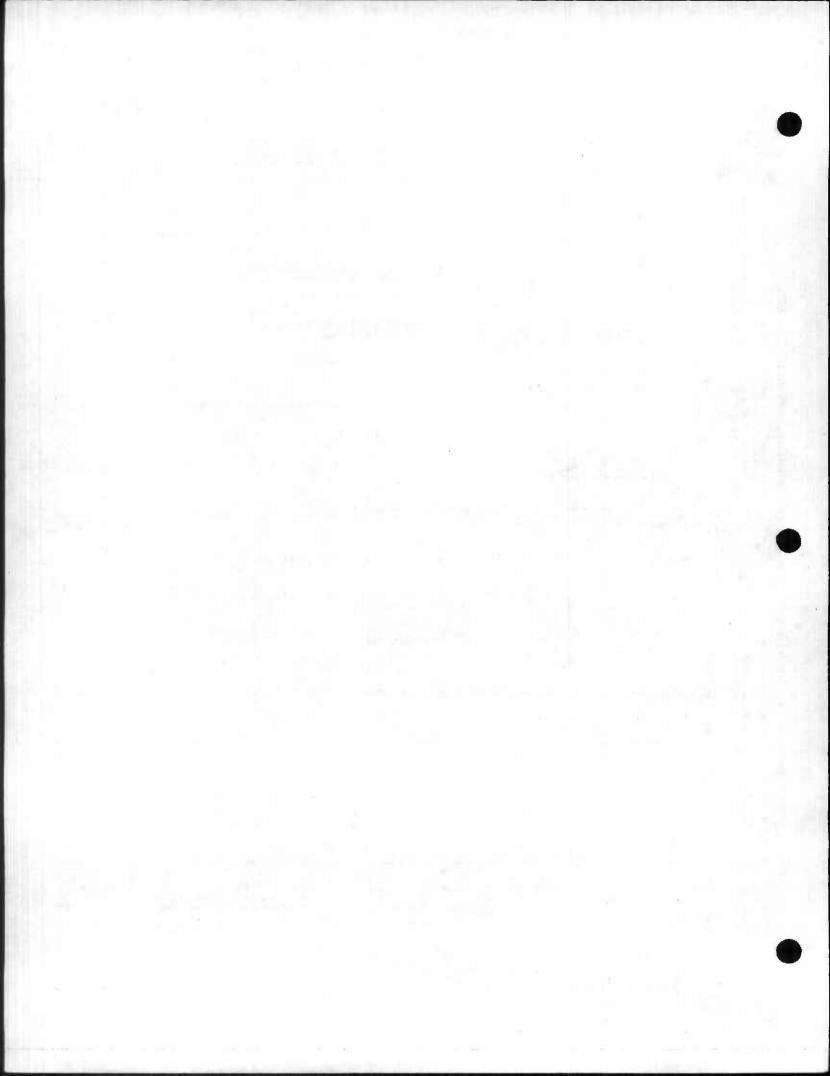
B. Sporker

111 Penn Street, Baltimore, Maryland 21201

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of Maryla		nent of F			giene	9	35108
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
Į.	Physici		Rettu	J	W	illia	MS	Novemb	Dey 1er 12 11	Year 7 9 9	19:11
W	/Medic		4a Facility Name (Wnot institution, give s	street and number)			4b. City, Town, or Lo		10		1 / / 11
	Examir	ner	Johns Hopki	11 /	ta (		BALTIMO	1			
-			5. Social Security Number 6. Sex			Inder 1 Year		8. Date of Birt	-	N/A	ce (State or Foreign
н	Funeral		10	M 2□F 47	Moi	nths Days	Hours Min.	(Month, Da	14,195	Countr	ce (Stete or Foreign
	Director		214-56-3963 Usual Residence of Decedent	A 4/		1	1.	0001	14,133	ZMAK.	LLAND
	Pue Maria		10a. State 10b. County	10c. (	City, Town or Location	1				100	d. Inside City Limits
	4 sh	0	MARYLAND N/A		BALTIM	ORE					Y☐ Yes 2☐ No
	100 th	Director	10e. Street and Number			f. Zip Code			10g. Citizen of V	/hat Countr	v?
	deeth with the Maryland ms 23s or 28s-f show						. =				
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20	9 9 1	by F	Milever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 🏋 No If Yes, Give Year or Dates:	10Y	es 2 No	Specify:		Specify	O-AM	ERICAN
21215-0020	"natural", or ha	B	15. Decedent's Educ		16a. Decedent's	Havel Occup	estion		16b. Kind of Bu	ninana/ladu	ata.
5	n 72	Completed	(Specify only highest grade		(Give kind o		during most of worki	ng	100. Killa di ba	3111953/11100	suy
12	within jene. The Med	E	Elementary/Secondary (0-12)	College (1-4or 5+)			•		HOMBE	DIIG	TNDCC
	TO CO. by See		17. Father's Name (First, Middle, Last)		HOUSEK	EEPER	18. Mother's Name	(First, Middle.	HOTEL		INESS
an	0 0 D A	Be C	JAMES HENRY	MITTTTAMC						-,	
3	should by nd Mente marked umatic ev	5	19a. Informant's Name/Relationship (Ty)		10h Mailine Ad	dance (Chand	and Number or Rurs		T REED	Chata 7in C	Sedal .
Maryland	0 0 0 0		TYRA L. FOSTER		ER 1001 N						
	Heelth Heelth Her tr	H	20a. Method of Disposition		. Place of Disposition		DI. AI	Date	20c. Location -		
סר	Peges nent of int: if it		1 Burial 2 □ Cremation 3 □ R	emovet from State	cemetery, cremetory	or other place					
듣	nit. Pe vartmen ordant: injury		4 □ Donation 5 □ Other (Specify)	-	ZION CE			.19,19	99 BAL	TO, N	MD.
Baitimore,	Department Department Important: any injury		21. Signature of Funeral Service License	. / /	22. Nan CAT	NE and Addre	S. SCRUG	S FUN	ERAL H	OME	
	F05#4		Remaduel	1. Accuse	2 141		PRESTON				21213
			23a. Part1. Enter the disease, or complication shock, or heart tailure. List only on	cations that caused and do	ath. Do not enter the	mode of dyin	ng, such as cardiac o	r respiratory a	rrest,		Approximate nterval Between
	Physician										Onset end Death
	/Medical Examiner		Immediate Cause (Finel disease or condition	pheumo	coccal	Dneu	monia			2	+ hours
	Examme		resulting in death)	Due to	(or as a consequence	-			•		L HOLET 3
	P #	Examiner	- 1	human 1	mmunod	eficien	ncu VIVU	s infe	CHON	112	War
	be executed sicien end burlei-transit	E	Sequentially list conditions,	•	(or as a consequence		9				0
760,	icien d		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							1	
876	hysic the b	lcai	that initieted events resulting in death) Last	Due to	(or es e consequence	e of):				1	
9	ing p	Me									
Box 68	The lew requires that the death certificate are been signed by the estending physpage 2 should be deteched for use as the	Completed by Physician/Med	0								
	be ed	응	Part II. Other significant conditions conf	tributing to death but not n	esulting in the underly	ring cause giv	ven in Pert t.	23b. Did 1	lobacco use cor	tribute to t	he cause of death?
P.0.	to the	Ph.	honotitic R 10	VII C				10	Yes 2 No	3 Probe	ibly 4 Unknown
Ś	the page	þ	nepatitis b vi	IN 2							
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æ	of se b	E	alcohol abuse	,				10	res 20 No	10	Yes 2□ No
ā	tiffica tor, p	Be C	25. Was case referred to medicat				26. Place of Deeth	(Check only o	ne)		
>	4 2 0	800	examiner?	ospitat:	☐ ER/Outpatient 3[	DOA Oth	ner _		dence 6 Oth	ar (Specify)	
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ō	Physic er this or eral dire	P	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at	28d. Describe I	now injury occurr	ed	
ou of	nding Physic ath. r: After this or e funeral dire	P	A		28b. Time of tnjury	28c. tnjur Wor 1 🗆	yat rk? Yes 2 □ No	28d. Describe I	now injury occurr	ed	
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Division of Vital Records,	al or Attending Physics effer death. I Director: After this or of in by the funeral directors.	P	27. Manner of Death  1) (Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	home, ferm, street, fe	10	Yes 2□No		Street and Numb		Route Number,
Division of	pepital or Attending Physic hours effer death. Inerel Director: After this of yillied in by the funeral dire	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  27. Manner of Death 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Specials)	thome, ferm, street, for	1 □	Yes 2 No	28f. Location (S City or Tow	Street and Numb	er or Rural i	ted.
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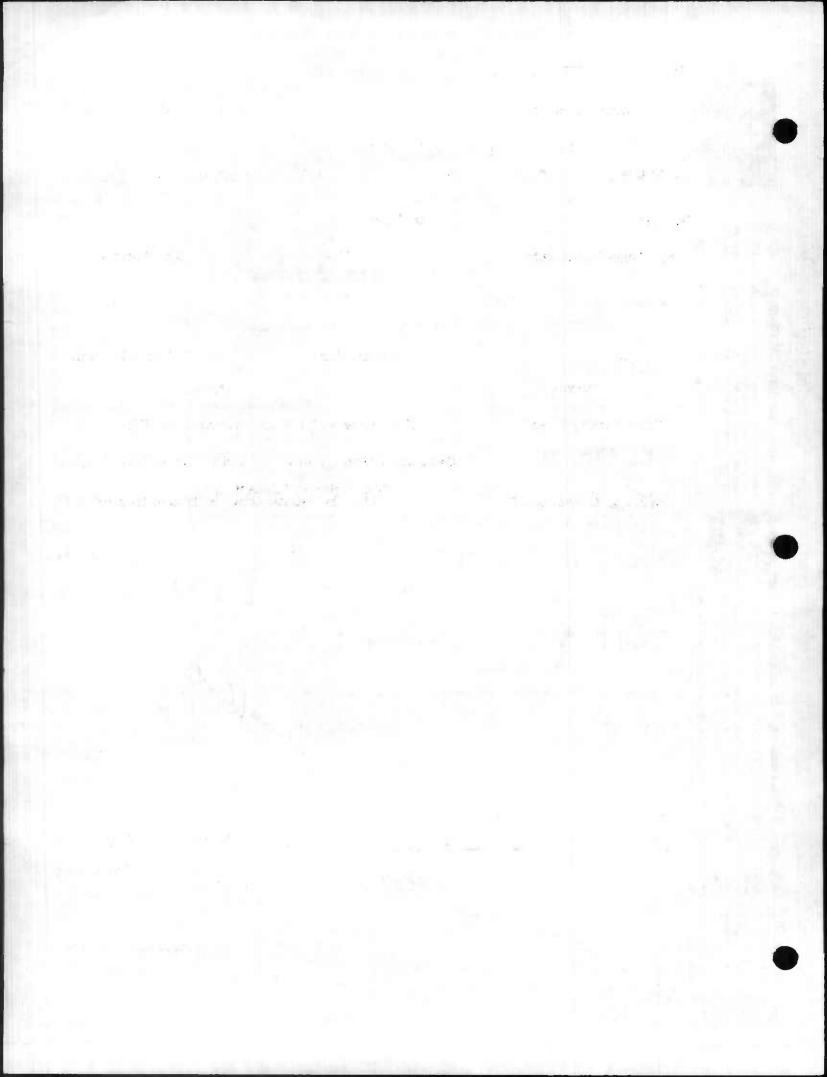


Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended	Item#28a perPhyG777 1	State of Maryla 1/19/99 EW		rtment of H			giene	)9 :	36109	
	1. Decedant's Nama (First, Middia, La					2. Data of De	eth .		3. Tima of Death	_
Physician	David Walte	rc				Month 100EM be	Day 12	1999	1615 pm	
/Medical Examiner	4a Facility Neme (If not institution, giv			4	b. City, Town, or L	14-	1	ty of Death	, , , ,	-
Examine	5	walty Hos	11	a.m.E	Roll	more				
Funeral	5. Social Security Number 6. S		s. last birthday)	If Undar 1 Yeer	If Undar 24 Hrs.	8. Data of Bir	th	9. Birthp	lace (Stata or Foreign	-
Director	214–38–0311	M 2□ F 65	Yrs.	Months Days	Hours Min.	(Month, Da April 21		Misso		
р	Usual Rasidance of Decedant									_
anyler show	10a. Stata 10b. County	10c. C	City, Town or Lo					1	0d. Insida City Limits  1    1    Yas 2   No	
r 28a-f show routed	Maryland		Baltim						77240	
2 0 2 0	10e. Street and Number			10f. Zip Code			10g. Citizen o			
s 23s	3843 Falls Road 2 Sc		11.6	21211		anife Van ar Na		States ace - Amaric		
items interme	11. Maritel Status  1 Never Married 2 Married	12. Was Dacedant Ever in Armed Forcas?  1 Yas 2 No	0,5.	Vas Decedant of Hi f Yas, specify Cuba	n, Maxicen, Puarto	Rican, atc.)	BI	ack, White,		
ors af	3₺ Widowed 4 Divorced	If Yas, Giva Yaar or Detas:		□ Yas 2 No	Specify:		Spec	ity: Whit	e	
	15. Decedant's Ed	fucation	16a. Daced	lant's Usuel Occupa	ation		16b. Kind of			1
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d with	12	College (1 45) 51)	M	anual Labor			Baltimo	re Pack	aging	
be filed within 72 ho tal Hygiene to other than 'nature event, the Medical Be Completed	17. Fathar's Nama (First, Middle, Last,	)			18. Mothar's Nam	a (First, Middla	, Maidan Suma	ama)		
should be and Mental marked o umatic eve	Unknown					Unkno	wn			
2 sho end is me sume	19e. Informant's Name/Ralationship (	Type, Print)	19b. Mailir	ng Addrass (Streat a	and Number or Au	ral Routa Numb	er, City or Tow	m, Stata, Zip	Coda)	
and ealth	Helen Martin/Fr			Falls Roa	d 2 South					_
Pages 1 nent of H nt: If fler iry or oth	20a. Method of Disposition 1 ☐ Burial 2 【▼Cramation 3 ☐		. Place of Dispo cematary, cran	sition (Neme of natory or other plac	(e)	Dete	20c. Location	n - City or To	wn, Stata	
ment:	4 ☐ Donation 5 ☐ Othar (Specif		-	Crematory,		11/14/99	Beltsvi	lle, M	aryland	
permit. Pages 1 and 2 should be filed within Depertment of Health end Mental Hyglene. Important: If Item 27 is merked other than sary injury or other traumatic event, the Meance.  To Be Completed.	21. Signature of Funaral Sarvice Licer	1588		. Nama and Addres AFA Stephe		ann. PA				
20500	Xaura C. Ha	rdesty		3/17 Green	Pastures D	rive Bal		Marylan	d 21286	
-	23a. Part 1. Entar tha disaasa, or com shock, or heart failura. List only	plications at causad the da ona causa on each lina.	ath. Do not ent	er the moda of dyin	g, such es cardiac	or raspiratory a	rrast,		Approximata Intervel Between	
Physician		Λ		4				- 1	Onsat and Death	١
/Medical Examiner	Immediata Causa (Final disease or condition resulting in deeth)	a. #2	piration	pneum	ionia			!	2 colous	
E 1			(or as a consec	uance of):	2000	1 40-6	ar reihi	10		
nsit		b. quadr			conse c	0	anajde	zn-	245	_
ate be executed hysician and the buriel-transit	Sequantially list conditions, if eny, laading to immediata ceusa. Entar Undarlying Ceuse (Disease or injury	Dua to	(or as a consac	uance of):				1		
2 E	Ceuse (Disease or injury that initiated avants	C. Due to	(or as a conseq	uenne of):				-		-
g phys as the	resulting in death) Last	Dua to	(or as a conseq	uance orj.						
attending p		d				- 1 1	20			_
death e atte	Pert II. Other significant conditions of	ontributing to death but not re	asulting in tha u	ndarlylng causa givi	an in Pert I	230 293	obacco use	ontribute to	the cause of death?	
requires that the death certific seen signed by the attending p thould be datached for use as the by Physician/Mee					^ 1	A SICAL 10	Yes 2 No	3 Pro	bably 4 Unknown	
igned to be dat					(1)	PA				
been signe should be					A PARTIE		an autopsy ormed?	av	ara autopsy findings ailabla prior to	
aw re as be 2 sh 2 sh					CATION			ol	mplation of cause death?	
The law requir				d	ENTERIO	10	Yas 2 No	10	Yas 2□ No	
certificate rector, pag	25. Was cesa refarred to medical axaminar?				26. Placa of Daa	th (Chack only	ona)			
hysicia this cert el direct	1 1 No 2 No		☐ ER/Outpatier		4 LI Nursing n	ome 5□ Rasi			y)	_
the range of the r	27. Manner of Death 1 ☐ Neturel 5 ☐ Panding	28a. Data of Injury (Month, Day Year)		Worl		pedestr			miniver	
leath lor: A the f	2 Accidant investigation 3 Suicida 6 Could not b	10-28-77	1845	7	Yas 2 1 No	1		/		_
tral or Attending P irs after death. al Director: After t lied in by the funere Certification:	4 ☐ Homicide determined	28e. Place of Injury - At building, atc. (Space	cify)	aat, factory, office		City or To	wn Stete	Flee	al Routa Number, t Street	
pital ours a rai C	29a. Certifier 1 Certifying Ph	veiden. To the best of my be			no data and place	Dalpm	ore, Hd			_
ne Hospi n 24 hound ne Funer pletaly fil	(Check only one)	ysiclan: To the best of my kr niner: On tha bests of axamir and mannar statad.	nation end/or in	estigation, in my of	pinion, daath occu	rred et the tima,	data and place	e, end due to	the cause(s)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completaly filled in by the fune. Medical Certification	29b. Signatura and titla of pertifiar	and manned states.		29c. Licansi	a number		29d. Data sign	ned (Month,	Day, Year)	
+ 5 + ō	-16			D :	30494		Novem	ber 12	1999	
$\bigcirc$	30. Nama and addrass of person who	complated causa of death (It-	am 23a) (Type	Print)	·			01:	2.4	
	. A	n meolical ann	V CIIC	Print) South cha	les st	Balha	nne 1	NYJYK	236	
State	31. Data filed (Month, Day, Year)	32. Registrar's Sig		Sparks						
Registrar	NOV 1 7 19	99 Anna	19.	Sparks						



P.O. Box 68760.

altimore. Maryland 21215-0020

show

or Attending Physician: The lew requires that the death certificate be executed Division of Vital Records, ne Hospital or Attending in 24 hours after deeth. he Funeral Director: After

certificate

After this

within 2 To the

Registrar **DHMH 16 Rev 6/95** 

State

29b. Signature and title of certifier

31. Date tiled (Month, Day, Year)

Davis

5601 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravan

29c. License number

20398

29d. Date signed (Month, Day, Year)

Blud Balto Mel 21239

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month James Linden Archibald, Sr. November 1120 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cecil Union Hospital of Cecil County Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10XM 2□ F Yrs. Director 217-20-0757 October 4, 1927 Maryland Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location Peges 1 and 2 should be filed within 72 hours after deeth with the Manylan neat of Health and Mental Hygiene.
Int: If item 27 is marked other than "naturel", or items 23a or 28a-f show mit; If item 27 is marked other than "naturel", or items 20a or 20a-f show my or other traumatic event, the Medical Exertise man to not infect any or other traumatic event, the Medical Exertise man to not other traumatic event, the Medical Exertise man to not other traumatic event, the Medical Exertise man to not other traumatic event, the Medical Exertise man to not other traumatic event, the Medical Exertise man to not other traumatic events. 10d. Inside City Limits 1 Yes 2 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21921 139 West High Street by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ঐYes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. WWII 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion
'Give kind of work done during most of working Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Chief 90 Weapons Facilities Elementary/Secondary (0-12) College (1-4or 5+) Division U.S. Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James L. Archibald Sadie Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy M. Archibald/ wife 139 West High Street, Elkton, Maryland 21921 20b. Placa of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 월 Burlal 2 ☐ Cremation 3 ☐ Removal from State Immaculate Conception permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 11/8/99 Cherry Hill, Maryland 21. Signature of Funeral Service Licansee 22 Name and Address of Fecility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 Elza 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel tyterioscler Fie Cardiovascula Disease disease or condition resulting in death) Examiner Examiner pertengion hysician end the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last P.O. Box 68760, Physician/Medical Accide sate has been signed by the atter-Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown settes Mellittu Records, þ Be Completed 24a. Wes an autopsy performed? 24b. Were eutopsy findings aveileble prior to completion of cause of death? 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: director. 25. Was case referred to medical 28. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖫 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Certification: To 1 Yes 2 No this filled in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending investigation within 24 hours after deeth.

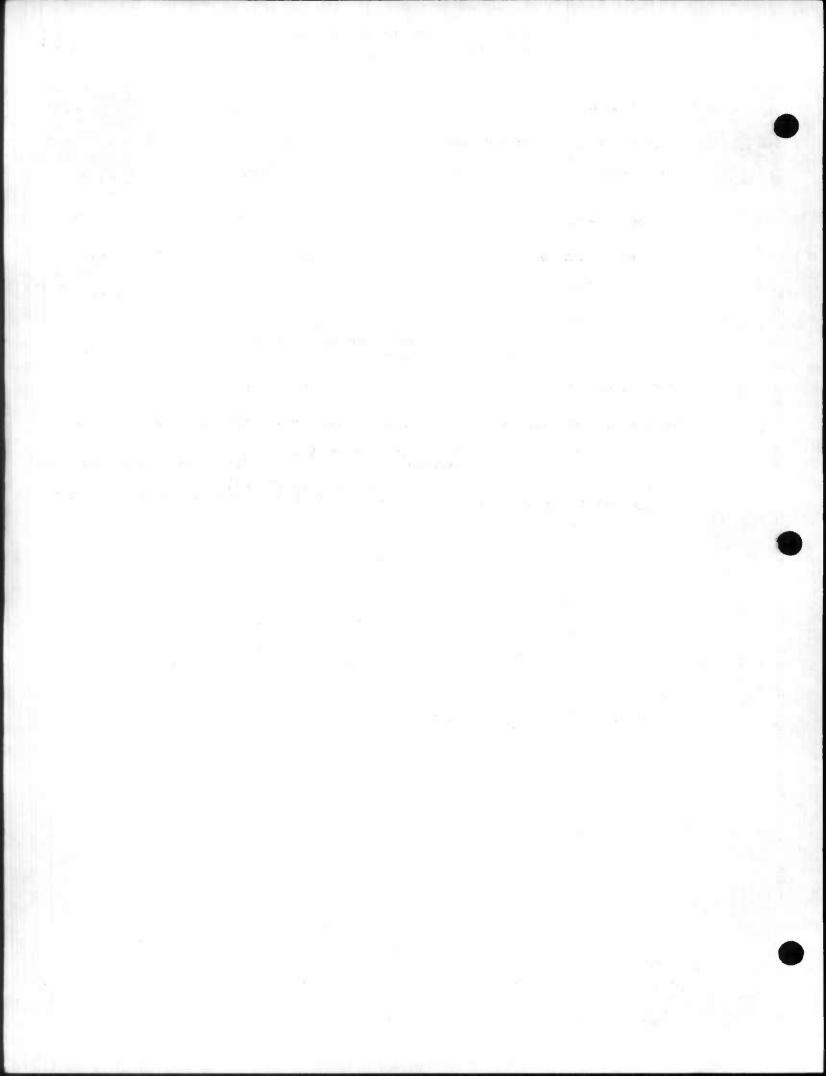
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) PATELMI) 123 Singerly Ave, ELKTON, MI) 21921 TAYANTILAL

State Registrar

VD

31. Date filed (Month, Day, Year) NOV 0 5 1999

32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 9	(

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 9:55AM Henry J. Burgett November 4 1999 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) **Examiner** VA Maryland Health Care System Perry Point Cecil 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 6. Sex 1 🕅 M 2 🗆 F 5. Social Security Number Birthpiece (State or Foreign Country) **Funeral** Deys Hours Yrs. Director 215-58-0638 June 11, 1910 Maryland Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or terms 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland | Cecil Perry Point Direct 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code VA Medical Center 21902 Funeral United States 12. Was Decadent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American indien, 11. Maritel Status Bleck, White, etc. hours after 1 ⊠ Yes 2 □ No If Yes, Give 1928 — Year or Detes: 1930 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White 1930 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filled within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 6 Never worked Never worked 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) nd Mental marked o should Henry Burgett Unknown 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code) . of Health Item 27 i Helen Guidice/ Social Worker VA Medical Center, Perry Point, Maryland 21902 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Pages Department of Important: If It any Injury or o 75 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State November Garrison Forest, 4 ☐ Donation 5 ☐ Other (Specify) 10, 1999 Maryland Veterans Cemetery Maryland 21. Signature of uneral Service Licerum 22. Neme end Address of Fecility Crouch Funeral Home Work 127 South Main Street, North East, Maryland 21901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximete intervei Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical 3 days Pneumonia Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequence of): physician s the burial 68760 Physician/Medicai that initieted events resulting in death) Lest Due to (or es e consequence of): the attending Box Pert II. Other significant conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? Ö signed by to 1 Yes 2X No 3 Probably 4 Unknown Schizophrenia þ 24b. Were eutopsy findings eveilebie prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed Multi Infarct Dementia has certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 N Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No this funeral 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i Hospital Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner es stated.

Medicel Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier edicai pletely (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 0 Allicici 151094-1 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) + IVA VA Maryland Health Care System Perry Point, MD 21902 Melecia Santos, M.D. 32. Registrer's Signature NOV 0 8 1999 State Registrar

DHMH 16 Rev 6/95

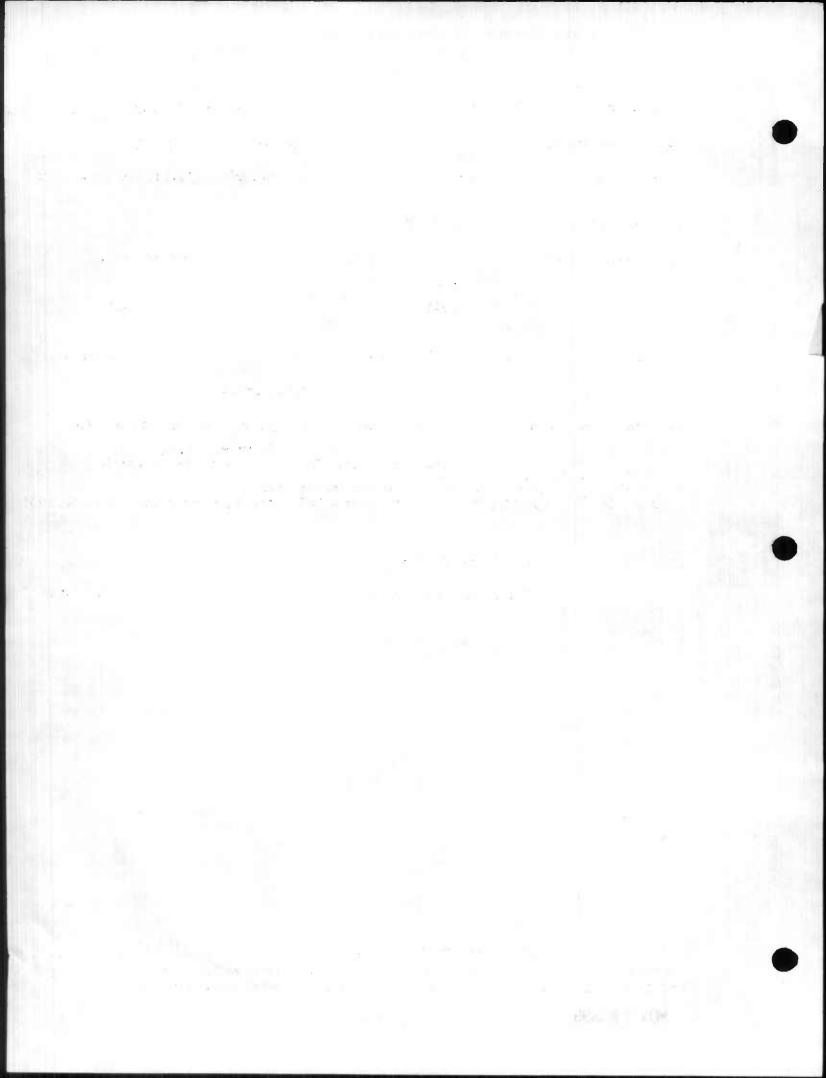
PHYSICIAN: Burgett, Henry J

NAME KNOWN TO

at long to a

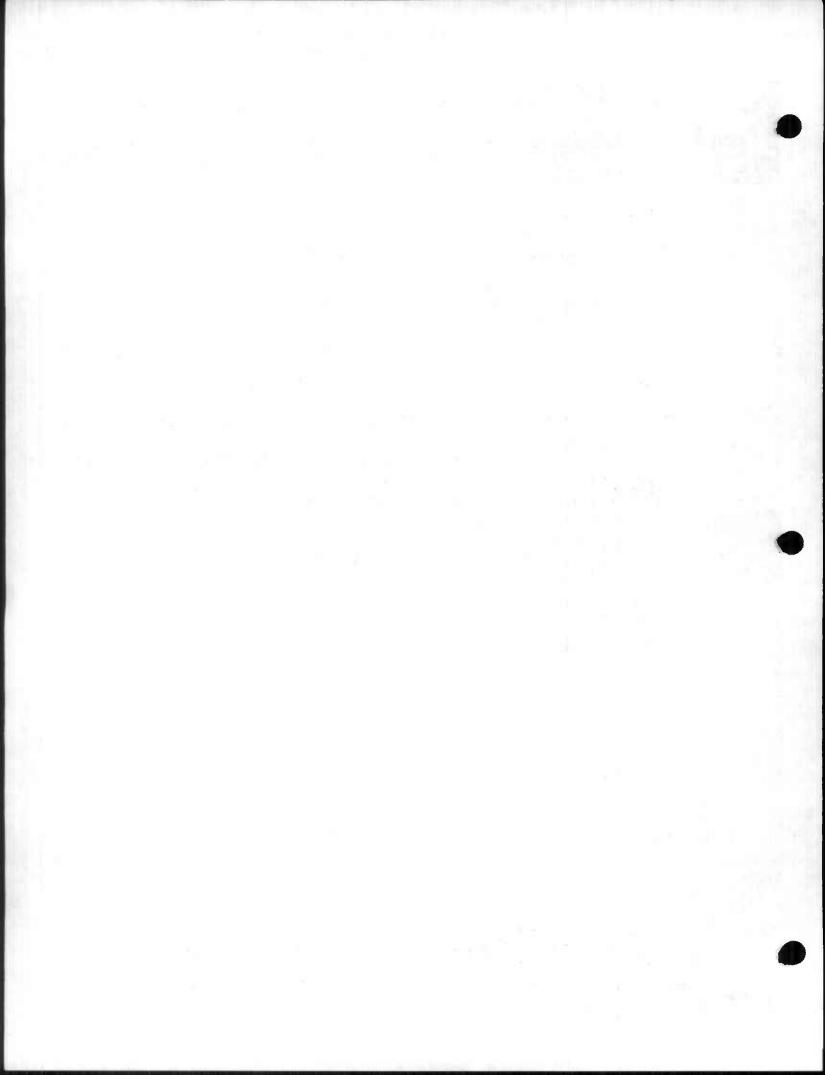
State of Maryland / Department of Health and Mental Hygiene ()

	Certificate of Dea	th R	eg. No.	6113
Physiciar	Decedant's Name (First, Middle, Last)	2. Date of Dear Month	Day Year	3. Time of Deeth
/Medica	Gilbert Angelo Bruno	November		10:55 A.M
Examine	4a Facility Name (If not institution, giva street and number) 4b. City,	, Town, or Location of Death	4c. County of Death	1
		h East	Cecil	
Funeral	1 M 2 F	irs Min. (Month, Day,		place (State or Foreign intry)
Director	Usual Residence of Decedent	November 1	1,1912 Mass	achusetts
yland	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mar	Maryland Cecil North East			1 ☐ Yes 2 No
or 28a-f s	10e. Street end Number 10f. Zip Code	1	0g. Citizen of What Cou	intry?
uth with the Marylan 23s or 28s-f show	52 Cherokee Drive 21901		United Stat	es
within 72 hours efter death with the Maryland ena. then "natural", or frems 23s or 28s-f show he Medical Evantine must be notified at	11. Marital Status 12. Was Decedanf Ever in U,S. 13. Was Decedenf of Hispanic	Origin? (Specify Yes or No-	14. Raca - Amer Black, Whita	
n 72 hours efter dea *natural, or ferms ed cal Examine (m.	1 Never Married 2 Married 1 1 Yes 2 No 1943 - 1 Yes 2 No Special		Specify:	, uto.
iral', o	3 KN Widowed 4 □ Divorcad Yaar or Datas: 1946		Whi	
ed within 72 hou ygjena. er than "natura ft, fn Wed cal	15. Decedent's Education (Specify only highast grade completed) (Give kind of work done during in	most of working	16b. Kind of Business/li	ndustry
within ena. then	Elementery/Secondary (0-12) College (1-4or 5+)			
73 50 60 50	12 4 Civil Engineer 17. Father's Name (First, Middla, Last) 18. M.	other's Name (First, Middle, I	Road Constr	cuction
Se se se			value? Camamey	
d 2 should the and Men 7 is market traumatic	Alphonso Bruno Va  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	aine Casassa	City of Town Chats 7	in Code l
C/ c/ 20 20 20				,
Hea The the	Richard Bruno / Son 52 Cherokee Drive  20a. Method of Disposition 20b. Place of Disposition (Nama of		Maryland 20c. Location - City or 1	
et 0 -	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cametery, crematory or other place)	November	West Cheste	er,
	4 Donation 5 Other (Specify) R.A. Ferris Co., Inc 21 Signature of Funeral Service Licensee 22. Name and Addrass of Fa		Pennsylvani	.a
pemit. Depertrimports any injuries	Crouch Funera	1 Home		
	127 South Main	n Street, Nort	h East, Mar	yland 21901 Approximata
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	i as cardiac or respiratory air	951,	Interval Between Onset and Death
Physician / /Medical	Immediata Causa (Final			
Examiner	disease or condition resulting in death)  a Respiratory Arrest			
	Due to (or as a consequenca of):		1	
axecuted in end iel-transit	b. Small Cell Lung Cancer  Sequentially list conditions  Due to (or as a consequence of):		1	2 months
n end iel-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury c.			
buricia	that initiated events			
00	resulting In death) Last			
attanding 1 for use as	d		1	
death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P.	art I. 23b. Did to	becco use contribute	to the cause of deeth?
iaw requiras that the death certias as been signed by the attanding 2 should be detached for use a		1 🔯 Y	es 2 No 3 Pr	obably 4 Unknown
as the				
been si should		24a. Was e	med? 8	Vere eutopsy findings vailable prior to
The law requir.			0	completion of cause of death?
0 - 0		1 🗆 Y	es 2 🕅 No 1	☐ Yes 2☐ No
certificate	25. Was case referred to medical 26. P	Place of Death (Check only or	10)	
Physician: this certific ral director,	examiner?  1 Yes 2 No Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	☐ Nursing Home 5 🛱 Reside	ence 6 Other (Spec	eify)
ar thi	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe h	ow injury occurred	
Attending I or death. ector: Attar by the fune	1 ⊠Naturel 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2	2 🗆 No		
after death Director: , d in by the	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (S City or Town	treet and Number or Ru n. State)	ral Routa Number,
tal or Attending P rs after death. al Director: After t ed in by the funera	Salaring Col. (Specify)			
24 hours Funeral letaly filled	29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion,			
To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by	one) and mannar stated.			
To the vithin 2 To the comple	29c. License numb	per 2	9d. Date signed (Month	, Day, Year)
	1 HO03	5860	1116195.	
6 + 1V1		5 Ogletown Sta	anton Road,	
6 T(V)	Dr. Irving M. Berkowitz, Christiana Hospital,	Stanton, I		
State	31. Data filed (Month, Day, Year)  32. Registrar's Signature			
Registra	NOV 0 8 1999 Severy B. Doarles			



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State of Maryland / Department of Health and Mental Hygiene	9	9	3	6	L
0. 110. 1 10. 11					

					Certi	ficate o	f Death	R	eg. No.		
Physicia /Modic		Decedent's Name (First, Middle, La ISOBELLA	EDITH	BUR	RNS			2. Date of Dea Month NOVEMBE	th Day	Year	3. Time of Death 2:50 A.M.
/Medic Examin		4e. Facility Neme (If not institution, give	e street and number)				4b. City, Town, or		4c. County		.50 A.H.
Funeral Director		229-30-0320		e (In yrs. le		f Under 1 Yea Months Day				9. Birthplace Country Canada	e (State or Foreign
Weryland 4 show	or	Usual Residence of Decedent  10e. State 10b. County  Maryland Char	les	10c. City	, Town or Locat						Inside City Limits
h with the ise or 28a.	Funeral Director	10e. Street end Number 10605 Mahogany	Court			10f. Zip Code	0601	1	Og. Citizen of V		?
permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Department of Health end Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28a-f show eny injury or other traumatic svent, its Med cal Examinal must be notified at once.	þ	11. Maritel Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 N I If Yes, Give Year or Dates:			s Decedent of es, specify Cu Yes 2 N	f Hispanlc Origin? (S uban, Mexican, Puerl o <i>Specify:</i>	pecify Yes or No- o Rican, etc.)		e - American ck, White, etc. : Whit	
ithin 72 ho ne. nan "netur . Wed cel	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+)		d of work don NOT use reti	ne during most of wo red)	1	16b. Kind of Bu		
ygier ygier yer th	S		2		Legal	Secret			Private		ffice
Mental H	To Be	17. Fether's Name (First, Middle, Last, James Carr						ne (First, Middle, Emily H		ne)	
alth end 27 is me		19a. Informant's Name/Relationship ( Loran C. Burns/Hu					et and Number or Ai ny Court,				0601
Peges 1 ent of He nt: If Item ry or other		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Special		ce	ace of Dispositi emetery, cremat itt Crem	ory or other p		Date 1-7-1999	20c. Location -		
Montal Manual Ma		21. Signaturaget Funeral Service Licer	<b>2</b> 000	01164	22 1	ame and Add	ress of Facility tt Funeral ( 156, Wal	Home, 1	nc.	20604	
ficete be physicie the bu	Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b. PROTEIN	CALO Due to (or	as a conseque	nce of): NUTRIT nce of):					
death cer	Physician/	Part II. Other significent conditions of	d	it not rock	Iting in the under	articles causes	given in Part I	23h Did t	phacen use on	ntribute to th	ne cause of death?
5 60 1		Tarm. Other algitudes it conditions to	ontributing to death of	10000	ating in the unde	mying cause	given in Faiti.				oly 4 Unknown
hes been signer and a should be	Completed by							24a. Was a perfor	med?	eveila	eutopsy findings ble prior to letion of cause ath?
cate he								1□ Y	es 2 No	1□Y	es 💯 No
Physicien: The this certificate ral director, peg	Be	25. Wes case referred to medical examiner?	Hospital:				Whos:	ath (Check only or			
Attending Physic death.  ector: After this by the funeral di	tion: To	1 Yes 2 No  27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injus (Month, Day		ER/Outpatient 28b. Time of Injury	28c. In	4 □ Nursing r	dome 5 ☐ Resid 28d. Describe h			
tal or Attendi rs efter death. al Director: A led in by the f	Certification:	3 Suicide 6 Could not b	28e. Place of Injubulding, etc	iry - At hoi : (Specify)	me, farm, street	, factory, offic	ө	28f. Location (S City or Tow	treet and Numb n, State)	ber or Rural R	oute Number,
Hospi 24 hou Funer tely fill	edicai	29a. Certifier (Check only one)  1	yaician: To the best on niner: On the basis of end manner sta	examinati	viedge, death or ion and/or inves	ccurred et the tigation, In my	time, dete end plece opinion, death occu	e, end due to the d urred at the time, d	euse(s) and me late and place,	enner es stete and due to th	e cause(s)
To the comple	Σ	29b. Signeture and the certifier	4 Fran	uj		OHIO	35-07-034	1-F N	29d. Date signe  OVEMBER		
		30. Name and eddress of person who	completed cause of de	eath (Item	23a) (Type, Pri						
Stat		THOMAS G FRASER, (31. Dete filed (Month, Day, Year)	CAPT, USAF 32. Registre		ure L	ANDRE	EWS AIR FO	RCE BASE	, MD 20	0762-66	500



		State of Maryland / Department of Health and M  Certificate of Death	lental Hygiene 99 36   15
ı	Physician	1. Decedent's Neme (First, Middle, Last)  Alice Brown	2. Dete of Death Month Dey Veer November 2 1999 8:25PM
	/Medical Examiner	45 Facility Name (If not institution give except and symbol)	
		106 Colton St. Upper Ma	
1	Funeral Director		8. Dete of Birth (Month, Dey, Yaer)  Dec. 13, 1938  9. Birthplece (Stete or Foreign Country)  Wash., D.C.
	pue M	Usuel Rasidenca of Decedant  10e. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Many Many Stor	Maryland Prince George's Upper Marlboro	1 🛚 Yes 2 🗆 No
	h with the Mar 23a or 28a-f a at be notified	10e. Street end Number 106 Colton Street	10g Citizen of Whet Country? United States
21215-0020	72 hours after death with the Manyland natural; or items 23a or 28s-f ahow iteal Examiner must be notified at sted by Funeral Director	11. Maritel Stetus  12. Wes Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Forced  12. Wes Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Specify:  1 Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No	ecity Yes or No- Rican, etc.)  14. Reca - American Indien, Bleck, White, etc.  Specify: Black
15-0		15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of working if the DO NOT use retired)	16b. Kind of Business/Industry
1121	within ena.	Elamantary/Secondary (0-12) Collaga (1-4or 5+) Housewife	Private
	be filed tal Hygi d other event, I Be Cc		e (First, Middle, Melden Surname)
ylar	Menta Menta	John Savoy, Sr. A	da Tyler
Maryland	12 sh hend 1 is m	19e. Informent's Name/Reletionship (Type, Print)  19b. Mailing Addrass (Street end Number or Rura	
	Healt Hem 2 other	Vicki H. Gordon - Daughter 10612 Broadleaf Dr., 20b. Placa of Disposition (Neme of	Upper Marlboro, MD 20774  Date   20c. Location - City or Town, Stete
mo	Pages ent of nt: If I	1X Buniel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)  Harmony Memorial Park 1	1/9/99 Landover, MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiena. Important: If Item 27 is marked other than any Injury or other traumatic event. In Mean 100ce.  To Be Complete.	21. Signature of Funerel Service Licensee 22. Nama and Address of Fecility S	tewart Funeral Home
		23a. Pertl Enter the disease, or complications that cause the distant. Do not enter the mode of dying, such as cardiac or shoot or heart failure. List only one causa on each line.	
	Physician /Medical Examiner	Immediate Ceuse (Final disaase or condition rasulting in daath)  e. METASTATIC AUUF CANCEIZ  Due to (or as e consaquence of): T	Onset end Death
Box 68760,	net the deeth certificate be axecuted by the attanding physician end latached for use as the bunial-transit Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate causa. Inlar Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last  b. Due to (or es e consequenca of):  C. Due to (or es e consequenca of):  d.	
	he atte	Pert II. Other signiticant conditions contributing to death but not resulting in the underlying causa given in Part I.	23b. Did tobacco use contribute to the cause of death?
s, P.O	requires thet the deeth certific seen signed by the attending phould be datached for use as hould by Physician/Met	Jul Collegi, 3	Yes 2 No 3 Probably 4 Unknown
Records,	been sig should b		24e. Wes en eutopsy performed?  24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
	The law requir sate has been s page 2 should	Diabetes Mellitus	1 □ Yes 2 ▼ No 1 □ Yas 3 ♥ No
of Vital	clan: artific ector.	25. Wes case referred to medical examiner?	h (Check only one)
	2 00	1 Inpatient 2 EH/Outpetient 3 DOA 4 Nursing Ho	me 5Ã Residenca 6 □Other (Specify)  28d. Describe how injury occurred
ion	Attending in deeth.  octor: After by the fune the fune fune fune fune fune fune fune fun	Natural 5 Pending (Month, Dey Year) Injury Work?  2 Accidant investigation M 1 Yes 2 No	
Division	tal or Attending P rs aftar deeth. al Director: After t led in by the funers Certification:	3 Suicide 4 Homicida  Could not be determined  28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)	28f. Location (Street end Number or Rural Routa Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completaly filled in by the funeral Medical Certification: 7		end dua to the ceuse(s) end mennar as stated. red et the time, date end placa, end due to the cause(s)
	within To the comp	29c. Signature and fittle of condition	29d. Date signed,(Month, Dey, Year)
	0	1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	11/03/95
	(10)	30. Name end eddress of person who completed cause of deeth (Item 23a) (Typa, Print)  William Du Boyce, MD 79 KETTERING Dr. Upper Mil	Pulboro, MD 20774
	State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 16 Rev 6/95

3 1399 there is the start

OPPLE B VOW

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death Per FAM. PGC 11-5-99 cr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:00 P.M. Franklin Berry November 4, 1999 /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Livingston Health Care Center Ft. Washington Prince Georges 5. Sociel Security Number 6. Sex 1X M 2□ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 578-32-7273 Yrs. November 15,1927 Maryland Director Usual Residence of Decadent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at Maryland Prince Georges Fort Washington 1 ☐ Yes 2 🛱 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11410 Fort Washington Road 20744 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 D Yes ART No If Yes, Give Year or Detes: 1946—1947 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Departmant of Health and Mental Hygiene. Important: If Item 27 Is merked other than "natural", or then any Injury or other traumatic event. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Supervising Operating Engineer D.C. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel S. Berry Goldie Raum 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11410 Ft. Washington Rd., Ft. Washington, MD 20744 June Tilch Berry/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 11/10/99 Cheltenham, MD 21. Signature of Funeral Service-bicensee 22. Name and Address of Fecility George P. Kalas Funeral Home, P.A. in Calas 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel a. As piraxian Prevmonitis

Due to (or as a consequence of): disease or condition resulting in death) Examiner Examiner ENDSTAGE PARKINSON'S physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause Completed 24a. Wes en autopsy performed? cate has of death? this certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica ately filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4₺ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending Investigation (XX)Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. To the Hospi within 24 hou To the Funer completely fill 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC00 7348 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert M. Nedzbala, M.D. 11701 Livingston Rd. #101, Ft. Washington, MD 20744

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 5 1999

100 6 5 1938 Same

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Dapartmant of Health and Mantal Hygians. Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: Tha law requiras that the death certificate be assocuted within 24 hours after death. Division of Vital Records, P.O. Box 68760,

Physici /Media		Earl Junior Cay						No	wonth vewb		PPP	1958
Examir	ner	4e. Fecility Neme (If not institution,		,				own, or Locatio	n of Death	4c. County	of Deeth	
_		Union Hospital  5. Sociel Security Number	of Ceci. 6.Sex	7. Age (In yrs.		If Under 1	E1kt	On	ate of Diet	Cecil	0.000	
Funeral Director		235-22-2096	1 X M 2 □ F	7. Age (m y/s.	Yrs.		Deys Hours	Min. 8. D	Month, Dey	, Year)	9. Birthplac	e (Stete or Fore
		Usuel Residence of Decedent						Ucto	ber 2	7, 1922	West \	Virgini.
<b>№</b> m		10e. Stete 10b. County		10c. Ci	ity, Town or L	ocation					10d	. Inside City Llm
투혈	jo	Maryland Cecil		Nor	th Eas							1 ☐ Yes 2 ☒
25 H	Director	10e. Street end Number		NOI	LII Las	10f, Zip Co	ode		- 1	10g. Citizen of V	Whet Country	?
200		36 Timberlane Dr	ivo			2100	1					
18.2	Funerai	11. Maritel Status		cedent Ever in U	J.S. 13.	2190 Was Deceden	t of Hispanic O	rigin? (Specify	Yes or No-	United 14. Rac	States e - American	
<u> </u>	E	1 ☐ Never Married 2 ☐ Marrie	Armed F d 1 X Yes	2 □ No		If Yes, specify	Cuben, Mexica	in, Puerto Ricar	n, etc.)		ck, White, etc	
0.0	þ	3 ☐ Widowed 4 🕅 Divorced	If Yes, G Year or	ive		1□ Yes 2X	No Specify	?:		Specify	Whit	0
nd Mantal Hygiane. I merked other than "natural", or itema 23a or 28a-f show umetic event, ita Medical Evaminet must be notified at	te	15. Decedent's	Education		16e. Dece	dent's Usual C	Occupation			16b. Kind of B		
E P	Completed	(Specify only highest Elementary/Secondary (0-12)	T .	) (1-4or 5+)	(Give	DO NOT use	done during mo retired)	st of working				
and Mantai Hygiane. Is merked other than aumetic event, the M	Ou	7	Оолодо	(1 401 54)	Heavy	Equip	ment Op	erator		Road Co	onstruc	ction
office Vent	Be	17. Father's Neme (First, Middle, Li	ast)							Maiden Suman		
Aanta rked tic e	To	Earl Caynor					Gra	ce Keen	er			
ama num		19a. Informant's Name/Reletionshi	p (Type, Print)		19b. Maili	ing Address (S	treet end Numb	per or Rurel Ro	ute Numbe	r, City or Town,	State, Zip Co	ode)
f Haalth and Mar tem 27 is marke other traumetic		Ernetta May Key	es / Dau	ghter	36 T	imber1	ane Dri	ve. Nor	th Ea	st, Mar	cvland	21901
e i i		20e. Method of Disposition		20b. I	Plece of Dispo	osition (Neme metory or othe	of		ete	20c. Location -	City or Town	, Stete
Dapartmant of Important: if it any Injury or conce.		1 X Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		State		ges Cei		Nove   9,19	mber	C+ Coo		D. 1
Dapartmant of Haalth Important: if item 27 any Injury or other tr once.		21. Signature of Funeral Setfilibe Li	• • • • • • • • • • • • • • • • • • • •	50			Address of Fecil		777	St. Geo	rges,	Delawar
Dapar Impor any Ir		100/11		6	C	rouch !	Funeral	Home				
	Н	23a. Pert1. Enter the disease, or c shock, or heart feilure. List or	n		1	27 Sout	th Main	Street	, Nor	th East	, Mary	vland 21
ysician Medical aminer		Immediete Ceuse (Finel disease or condition resulting In death)	e		SCV b							ears
nsit	Examiner		b									
attanding physician and for usa as the bunal-transit		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury		Due to (	or es e conse	quence of):						
lysici ne bu	sician/Medical	that initieted events	C	Due to (d	or es e consec	quence of):					-	
as th	Jed	resulting in death) Lest										
andir r usa	an/l		d									
0 2	sicia	Pert II. Other significant conditions	s contributing to d	leath but not res	sulting in the u	inderlying caus	se given in Pert	i.	23b. Did to	obacco uea co	ntribute to th	e causa of dea
igned by the	Phy					,,	9			es 2 No	3 Probab	
pe da	by F										0_,,,,,,,,	, , ,
been sig									24e. Wes e		24b, Were	eutopsy finding
s pee	Completed								perfor	med?		ble prior to letion of cause
paga 2	mo								1 🗆 Y	es 2 <b>X</b> /No		1
cartificate rector, pag		25. Wes case referred to medical					no Die	- of Darth (Oh			1 U Y	es Joyno
	o Be	exeminer? 1 ☐ Yes 2 ②No	Hospital:	Inpatient 2K	ER/Outpetier	nt 3 DOA	Other:	e of Death (Ch				
	<u>-</u>	27. Menner of Deeth		of Injury oth, Day Year)	28b. Time o		Injury et Work?			ence 6 Oth		
: Afta	tion	1 Naturel 5 Pending 2 Accident investiga		nth, Dey Year)	Injury	М	Work? 1 ☐ Yes 2 ☐					
octor by th	fice	3 ☐ Suicide 6 ☐ Could no	t be 28e. Plec	e of Injury - At h	ome, farm, sti	reet, factory, of	ffice	28f. L	ocation /S	treet and Numb	er or Rural R	oute Number.
d in t	Certification:	4 Homicide	build	ling, etc. (Specil	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	n, State)		,
To the Funeral Director: Affar the complately filled in by the funeral	edicai C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Phyeician: To the saminar; On the b	e best of my kno easis of exemina nner stated.	owledge, deetl ation end/or in	n occurred et t vestigation, In	he time, date er my opinion, dea	nd plece, end d ath occurred et	ue to the ca	ause(s) and me late end place, o	nner es stete end due to the	ed. e cause(s)
To th	ž	29b. Signature and title of certifier				29c. L	icense number		2	9d. Dete signed	d (Month, De)	y, Yeer)
		THOUR	2			N	SUISO	5		soveau k	Seis H	1999
/^		30 Name and address of the second	no complete d ac	on of don't /ti-	n 03e) (T		00,00	, _		JUCK WE V	500	,
t IVA		30. Neme end address of person wh	ю completed cau	se of death (Iter	n 23e) (Type,	Print)						

union Hospital

32. Registrar's Signeture

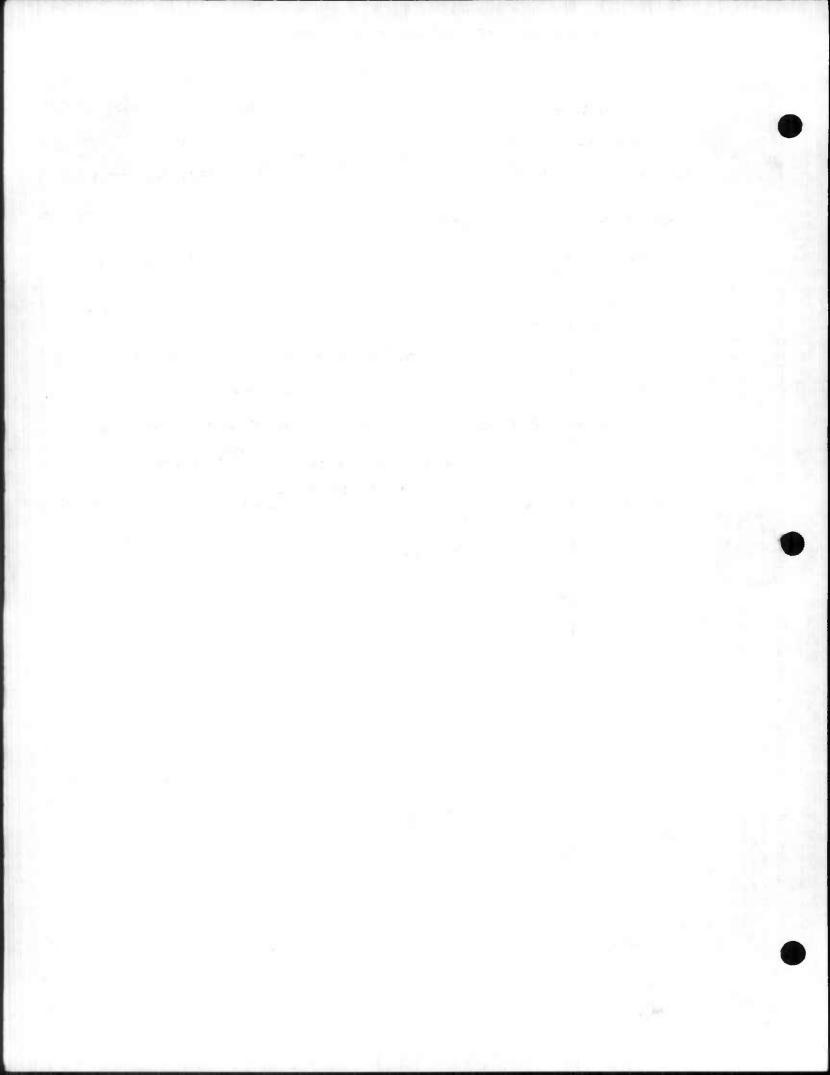
106 BOW ST ETICTON, MD 21921

Registrar DHMH 16 Rav 6/95

State

Stephanie OAcqa MD

31. Dete filed (Month, Day, Year)
NOV 0 8 1999



State of Ma	ryland / Department of Health and I	Mental Hygiene 9	3611
	Certificate of Death		

				Ce	ertificate o	f Death		Reg. No.		
		1. Dacadant's Name (First, Middla,	Last)				2. Data of D Month	aath	Vana	3. Tima of Death
Physicia /Medic		WILLIAM	COOPE	R			NOVEMB	ER, 3	1999	6-10 PM
Examin		4a. Facility Nama (If not institution,				4b. City, Town, or			of Daath	
		Bayside Care	Center			Lexingto	n Park	St.	Mary'	s
Funeral Director		5. Sociel Sacurity Number 24-13-24-71	S. Sax 7. Aga (In 1  M 2  F	yrs. last birthday 91 Yrs.	If Under 1 Yas   Months   Day		(Month, D	rth a <i>y, Year)</i> 16, 1908	9. Birthp Coun Sout	placa (Stata or Foreign htry) th Carolin
pu 🛾		Usual Rasidance of Decedant  10a. Stata 10b. County	100	. City, Town or L	nestina					
sho sho	7								1	0d. Insida City Limits 1 X Yes 2 □ No
Ne M	Director	Maryland St. Ma	ry's	Lex	ington P					
3e or	al Dir	10e. Street and Number 21412 Great Mi	.11s Road		10f. Zip Code	0653		10g. Citizan of Unite		
deeth	Jers	11. Marital Status	12. Was Decedent Evar	in U,S. 13.		f Hispanic Origin? ( uban, Maxican, Pua	Specify Yas or N		e - Amaric	
urs ai', c	by Funeral	1 ☐ Navar Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armad Forces? d 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Datas:		If Yes, specify Co		rto Ricen, etc.)	Specif	ck, White, y: B1	etc. .ack
72 ho	Completed	15. Decedant's (Specify only highast	Education	16a. Dece	edant's Usual Occ	upation	ndrina	16b. Kind of B	usinass/Ind	dustry
Ithin ne.	nple	Elementery/Şecondery (0-12)	College (1-4or 5+)	lifa.		ne during most of wo	Ji King	Des		
led w lygier nt, th	ပိ	6th			Farmi				ivate	*
uld be fil Ventel H rksd ott	To Be	17. Father's Neme (First, Middle, Le Unknow	•			18. Mothar's Na	ıma <i>(First, Middle</i> Unkn	a, <i>Maidan Sum</i> an OWN	na)	
2 sho end 1 e me		19a. Informent's Name/Ralationship	(Type, Print)	19b. Mail	ing Addrass (Stre	et and Number or F	lura <i>i Route N</i> umi	er, City or Town	State, Zip	Code)
end saith n 27 ier tr		James Lucas -	Son-in-Law	37	099 Ashe	r Road, N	lechanic	sville,	MD	20659
parmit. Pages 1 and 2 should be filed within Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Motos.		20a. Method of Disposition  1	☐Removal from Stata	cematary, cra	ositlon (Nama of matory or other p Memoria		Data 11/9/99	20c. Location Lando		
parmit. Departminents imports any inju		21. Signature of Juneral Service Lit	bensee &	2	2. Nama and Add	rass of Facility	Stewart	Funeral	Home	
88388		1 John T	Stones I		4001 Ben	ning Rd.,				20019
Physician /Medicai Examiner	er	23a. Part I Anter the disease, or a shock or heart failura. List or Immediata Causa (Final disease or condition resulting in death)	a. — — Dua i	pero	tenniquance of):	m				Approximate Interval Between Onsat and Death  4 Yeary
ertificete be ling physicia e es the bu	In/Medical Examiner	Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undaryling Cause (Disaase or Injury that Initiated events rasulting In deeth) Last	C	to (or as a conse		art F Lure	arlu			
the atte	Physician	Part ii. Other significant conditions	contributing to death but not	rasulting In the u	undariying ceusa	givan In Part i.	23b. Dld	tobacco use co	ntribute to	the cause of death?
that the dended by the se deteched							1 🗆	Yes 2D No	3 Prot	bably 4 Unknow
ew requires se been sig 2 should by	Completed by							s an autopsy ormed?	ave	ara autopsy findings eilebla prior to mpletion of causa death?
The la	EO						10	Yas 20 No	10	Yas 20 No
iclen: The	Be (	25. Was cesa referred to medical axaminar?				26. Placa of De	eth (Check only	ona)		
nysic ils ce	0	1 Yas 2 No	Hospital: 1 Inpatiant	2 ER/Outpatie	nt 3□ DOA	her: 4 Nursing	Homa 5□ Ras	idance 6 Oth	ar (Specif)	y)
h. After ti funere	Certification:	27. Mannar of Death  1 Neturel 5 ☐ Pending 2 ☐ Accident Invastigal		28b. Tima o Injury	W	uryat ork? ⊒ Yes 2 ⊒ No	28d. Describe	how injury occur	red	
al or Attending Physicien: The law requires that the seffer deeth.  I Director: After this certificate has been signed by the differthis tunerel director, page 2 should be deteched.	Sertific	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicida detarmine		At homa, farm, st ecify)	raat, fectory, offic	9	28f. Location City or To	(Street and Numb wn, Stata)	er or Rura	l Routa Number,
To the Hospital or Attan within 24 hours effer deet To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Cartifying (Check only one) 1 Medicai Ex	Physician: To the bast of my aminer: On the basis of axam and manner stated.	knowladge, deet nination and/or In	h occurred at the westigation, in my	time, deta and plac opinion, death occ	e, and due to the urred at tha tima,	ceuse(s) end me data and plece,	ennar es st and dua to	eted. tha cause(s)
To the	Me	29b. Signatura and titla of certifiar			29c. Lica	nse number		29d. Data signe	d (Month, I	Day, Year)
		) SC	Gaby		D:	5434	6	11/	3/9	19
(2)		30. Nama end addrass of person who CHANDR S 31. Data filed (Month, Day, Year)	o complated ceusa of death (	Itam 23a) (Type,	Print) PHIL	IPJ B	EANN	IEDICAL TCH RD	CE	NTER
Stat	e	31. Data filed (Month, Day, Year)	32, Ragistrar's Si	Ignatura		1 1011	1	1D 206	36	1 wood)
Registra	•	NOV 0 5 199		A	1.					

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#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** ephas rose 30,1999 Marie Actober 0855 /Medical 4c. County of Death 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Hospita Cambridge ... If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) GENERAL ORChester Dorchester 7. Age (In yrs. last birthdey) 55 Yrs. 5. Soclei Security Number If Under 1 Year 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 M 2 M F Months Deys 213-42-0480 Director Dec. 04.1943 Makyland Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director )orchester Vienna 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? must be or 12. Wes Decedent Ever in U.S. Armed Forces? 21869 Road the Medical Examiner ma Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mantel Stetus 14 Rece - American Indian Bieck, White, etc. 1 Never Merried 2 Merried 1 Yes 21 No altimore, Maryland 21215-0020 Specify: If Yes, Give Yeer or Detes: p Specify: Black 3 Widowed 4 □ Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Rebabilitation Center Counselor 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be is marked of Pages 1 and 2 should be McCready ter 2 e James Alice Johnson 19b. Matting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 803-Center Street Cambridge, Maryland 21613 leca of Disposition (Neme of Dete 2002. Location - City or Town, Stete ephas Kevin Department of Health Important: If Item 27 i 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 8 11/65/99 FORK Neck Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Vienna, Maryland 22. Name end Address of Fecility Henry Funeral 21. Signeture of Funeral Service Licensee HOME P.A. le Cambridge, Maryland 21613 510 Washington St 23a. Pert1. Enter the disease, or complications that caused the detail. Do not enter the mode of dying, such shock, or hear feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) Cardiopulmonar /Medical Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury burial-tran requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, the attending physician thed for use es the buria Physician/Medical thet initieted events resulting In deeth) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. detached 23b. Did tobacco use contribute to the cause of death? 4) Unknown 1 ☐ Yee 2 ☐ No 3 Probably δ 8 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? Deen 2 this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐No Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how Injury occurred : After t 5 Pending investigation 1 Neturei deeth. 1 Tes 2 No To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner es steted. | Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pieca, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only

29c. License number

29d. Dete signed (Month, Dey, Year)

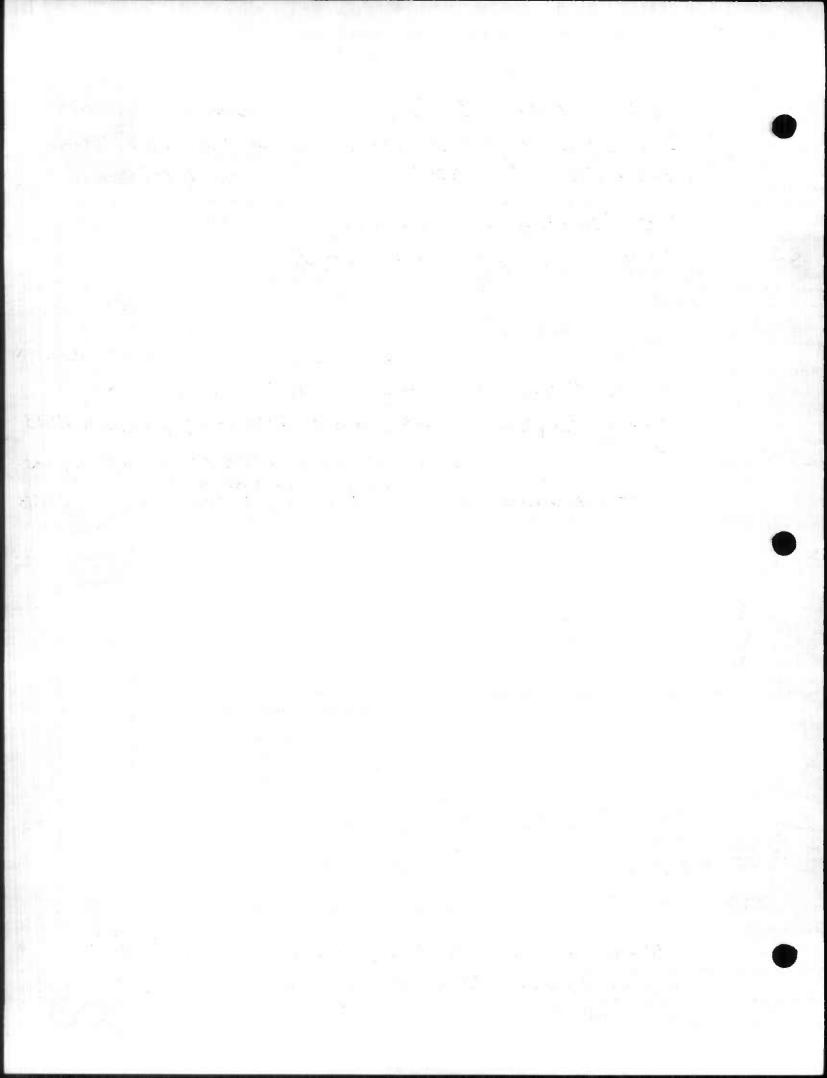
Cambri

State Registrar 29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year) NOV 0 2 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene QQ

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Physician /Medical	Decedent's Neme (First, Mid		NA LUCY D	ESMARAIS	4	2. Dete of Dec Month NOVEMBI	ER 3, 19		ime of Deeth
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Hygiene.  Ther than 'naturel', or thems 23a or 28a-f show and the Medical Examiner must be northed at the Medical Examiner must be northed at the Medical Examiner must be northed at the Medical Examiner must be northed at the Medical Examiner must be a completed by Funeral Director	5. Social Security Number 024-22-0961 Usuel Residence of Decedent	6. Sex 1 □ M 2√7 F	ge (In yrs. last birth 69	Months De	ear If Under 24 Hrs bys Hours Min	8. Dete of Birt Month, De November	h y, Year) - 9,1929	9. Birthpiece (S Country) Massac	State or Foreighusett
Hed at	10e. State 10b. Count	v ce George's	Camp Sp:						ide City Limit Yes 2 X N
23a or 28a-f s lat be norified af Director	10e. Street end Number 5004 Rayburn	Court		10f. Zip Coo	0748		10g. Citizen of V	Whet Country?	
important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be northed at some.  To Be Completed by Funeral Director	11. Maritel Status  1 □ Never Married 2 ☑ Me 3 □ Widowed 4 □ Divorce	12. Wes Deceden Armed Forces 1 Yes 201	KNO S	13. Wes Decedent	of Hispenic Origin? (S Cuban, Mexican, Pue	Specify Yes or No to Rican, etc.)	14. Rec Biad	e - American Ind ck, White, etc. White	ien,
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T	19e. Informent's Name/Relation		19b. I	Mailing Address (Str	reet end Number or R			Stete, Zip Code)	
er tra	Armand J. Desi	marais/Husba	nd	Same as i	tem 10				
ry or oth	20e. Method of Disposition  1 ☑ Buriel 2 ☐ Cremetion  4 ☐ Donetion 5 ☐ Other (		cemetery,	isposition (Neme of cremetory or other	plece) al Cemeter	Dete		City or Town, St	
any inju	21. Signature of Funeral Service	P. Falas	172.5.2115.0.	George P		ineral Ho	ome, P.A	1.	4 U
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Be C	25. Wes case referred to medic examiner?	ai			26. Plece of De	eth (Check only o	ne)		
al dire	1 ☐ Yes ŽÍXNo	Hospitel: 1  Inpat	-		Other: 4 Nursing	1 - 1	dence 6 Oth		
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To the Fundral Director: Anel fins carinicate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	4 Homicide	mined 200. Pleca of it	njury - At home, ferm rtc. <i>(Specify)</i>	, street, fectory, off	ice	28f. Location (S City or Tov	Street end Numb vn, Stete)	per or Rurel Rout	e Number,
To the Funeral Director: After complately filled in by the funer Medical Certification	29e. Certifier XX Certify (Check only one)	ing Physician: To the best I Examiner: On the basis and menner s	of examinetion end/	leeth occurred at the prince of the prince o	e time, dete end piec ny opinion, deeth occ	e, and due to the urred et the time,	ceuse(s) end me dete end place,	enner es steted. end due to the ca	ause(s)
N N	29b. Signeture end fitte of certification of the property of t				ense number		29d. Dete signe NOV. 4,	d (Month, Dey, Y	'ear)

DHMH 16 Ray 6/95

State Registrar

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 1:15 pm Nevember Eleanor M. Durbin 2 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Doctor's Community Hospital Prince George's Lanham 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (tn yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2\ F Months Days Hours Yrs. 185-05-5701 81 Feb. 17, 1918 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 N Yes 2 No Maryland | Prince George's College Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5705 Berwyn Road 20740 U.S.A. 14. Race - American Indien, Bleck, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Married 2 Merried 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 3 ଔ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum Physician /Medical

Physician

/Medical

Examiner

**Funeral** 

Director

must be notified at

Nerns 23s

Baitimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

Pages 1 and 2 should be nent of Health and Mental

Eleanor

Directo

Funeral

Be

2

Examiner

physician and s the burisi-transit requires that the death certificate be executed signed by the or Attending Physician: this After this funeral ie Hospital or Attention 24 hours after death.
the Funeral Director: Aftremental Directors of the Funeral Director and the Funeral Director and the Funeral Director and the Funeral Director and the Funeral Director and T

Examiner Physician/Medical à Completed 8 Certification: To 29a. Certifier (Check only one) Medical

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in death) Last

17. Father's Name (First, Middle, Last)

20a Method of Disposition

William I. Miller

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

19a. Informant's Name/Relationship (Type, Print)

Charles G. Durbin, Jr. - Son

1X Burial 2 ☐ Cremation 3 ☐ Removel from State

Kari Due to (or as a conge-

Mades

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

asch

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Baltimore National Cemetery 11/08/99

Gasch's Funeral Home, P.A.

22. Neme and Address of Fecility

Due to (or as e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐dInknown

20c. Location - City or Town, State

Baltimore, Maryland

24b. Ware eutopsy findings evailable prior to compelion of cause 24a. Wes an eutopsy performed?

1 Yes 2 No

18. Mother's Neme (First, Middle, Maiden Sumame)

Wilhelmina Roessing

Dete

19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

4739 Baltimore Avenue, Hyattsville, MD

4522 Catterton Road, Free Union, Virginia

1 ☐ Yes 2 🕱 No

22940

20781

Approximete Intervel Between Onset and Death

25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2E No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State)

6 Could not be detarmined 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide

DE Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and manner es stated.

| Medical Examples: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the fier: On the basis of axamination and/or investigation, in my opinion, death occurred et tha time, data end place, and dua to the ceuse(s) and manner stated.

29b. Signature and title of certifier 0

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) EUZABETH KIMMETT 1351 GREENBRIAR RD,

31. Date filed (Month, Day, Year) NOV 0 5 1999

32. Registrar's Signature

Registrar

To the Hosp within 24 ho To the Fune completely fi

phone of steady

HOV 9 5 1999

1. Decedent's Name (First, Middle,	Last)					:	2. Dete of Dea		Yeer	3. Tim
Leota Marga	aret D	enevan				1		er 2, 1		13
4a Facility Name (If not institution,	give street and num	ber)			4b. City, To	own, or Loc	ation of Deeth	4c. Count	y of Deeth	
Anne Arundel Me 5. Social Security Number		ter 7. Age (In yrs. las	et frietheford	If Under 1 Ye		polis	Date of Bid		Arun	
218-20-1485	1 M 2 N F	86	Yrs.	Months Day		I Min.	B. Date of Birt (Month, De) Dec. 7	Y. Year)	9. Birthp Cour Sout	h De
Usual Residence of Decedent						1 1	,	, 1714		
10a. State 10b. County		10c. City, 7	Town or Loc	ation					1	lOd. Insid 1█\ Î
	George's	(	Colleg	e Park				10- 05	Mills and Course	
10e. Street and Number 8704 49th Aver				10f. Zip Cod	9 740			10g. Citizen of U.S		ntry r
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1 Never Married 2 Merrie	Armed Ford	2K No					ican, etc.)		ock, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or De	les:	1	□Yes 2∭ N	lo Specify.	7:		Specil	Whit	te
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Elementary/Secondary (0-12)	College (1-	4or 5+)						Prince		-
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Louis Byron A					Mar		ussaini			
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20a. Method of Disposition		20b. Plac	e of Dispos	ition (Name of story or other)		1	Dete	20c. Location		own, Sta
1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Sp.		tate		ion Ce		111	/05/99	Clinto	n M	o r 17 1
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Summer to about 656: 3.0

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 36123

				Cer	tificat	e of	Death	F	Reg. No.			
Di	1. Decedent's Name (First, Middle, Last						2. Dete of Deeth Month Day Yo		3. Time of Death			
Physician /Medical	LILLIAN B. EVAN						Novembe	r 3, 19	99	6:00 P.M.		
Examiner	4a Facility Neme (If not institution, give	street end number)					4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
	Collington Epis	Mitche	hellville Prince George's									
uneral Director							If Under 24 Hrs Hours Min.	(Month, De)	8. Date of Birth (Month, Dey, Yeer) 9. Birthplece (State or Fr Country) Virginia			
>	Usual Residence of Decedent				10	ed Impide Oltr I imite						
show	10e. State 10b. County				10	d. Inside City Limits  1  Yes 2 No						
28a-f sho notified at							ville			Og. Citizen of Whet Country?		
when the state of thems 23s or 28s-f's which have been ordered to the Medical Examiner must be notified Completed by Funeral Director	10e. Street end Number 10450 Lottsford Road						Zip Code 20721			United States		
	11. Maritel Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Tyes 2 d If Yes, Give Yeer or Dates:	1 Yes 2 No If Yes, Give				dispento Ortgin? (Sen, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	ican, etc.) Blad		ace - American Indien, ack, White, etc. ify: Black	
	(Specify only highest grade completed)  Elementary/Secondery (0-12) College (1-4or 5+)				Decadent's Usuel Occupation     (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
vent, th	17 Eathara Nama /First Middle Leath	5+		Teacher				mo (Firet Middle	Government ne (First, Middle, Maiden Sumame)			
2 a m	17. Fether's Neme (First, Middle, Last) Thomas Ball							erta Nor				
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If Nem 27 is marked or other treumatic ev	19a. Informent's Name/Relationship (T) Junius JeffriesI		n-Law	1045	0 Lot	ttsf		Mitchel			20721	
ant: If Hen	20a. Method of Disposition  1X Buriel 2 Cremetion 3 F  4 Donetion 5 Other (Specify)		cam	e of Dispose etery, crem ah Ba	etory or o	ther pla	ca) Cem.	Dete 11/9/99	20c. Location Mino	r, VA		
Important: if item 2 any injury or other once.								Stewart Funeral Home N.E. Wash., D.C. 20019				
sician edical miner	23a. Pert1. Inter the disease, or comp shock of heart feilure. List only of Immediate Ceuse (Final disease or condition resulting in deeth)	a. Myc)									Approximete Intervel Between Onset end Death	
in end iel-trensit Examiner	Sequentially list conditions,	b										
s the bur	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	thet initiated events										
for use										i		
sicis	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pe						ven in Pert I.	23b. Did t	23b. Did tobacco uee contributa to the c		the cause of death?	
d by Physician/M								1 Yes 2 No 3 Probably		ably 4 Unknown		
shou	Avenia	Multiple Myeloma Avemía						24a. Wes en eutopsy performed?		24b. Were eutopsy findings eveileble prior to completion of cause of deeth?		
paga 2	Van Vialenal	Penkinson's Disease						101	res MINo	1	Yes 2 No	
o o	25. Wes case referred to medical	S NO STEEL	dist.				26. Place of Do					
his cartificate il director, pag To Be Co	evaminer? -	examiner?						26. Plece of Death (Check only one)  Other: Survival Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)				
£ 7	27. Manner of Death			Bb. Time of				28d. Describe h			/	
To the Funeral Director Affar the completely filled in by the funeral Medical Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work?  M 28c. Injury et Work?  M 1 ☐ Yes 2 ☐ No  28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						28f. Location (Street end Number or Rural Route Number, City or Town, State)				
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)  29 Medical Exami	nar: On the basis o	f exeminetion									
Med Med	1	and menner st	eted.		204	r Licen	se number	urred et the time, date end place, end due to the cause(s)				
23	29b. Signeture and title of confiner  29c. License number  297. License number							3 29d. Date, signed (Month, Dey, Year) 11/04/99  Aper May boro, un 20774				
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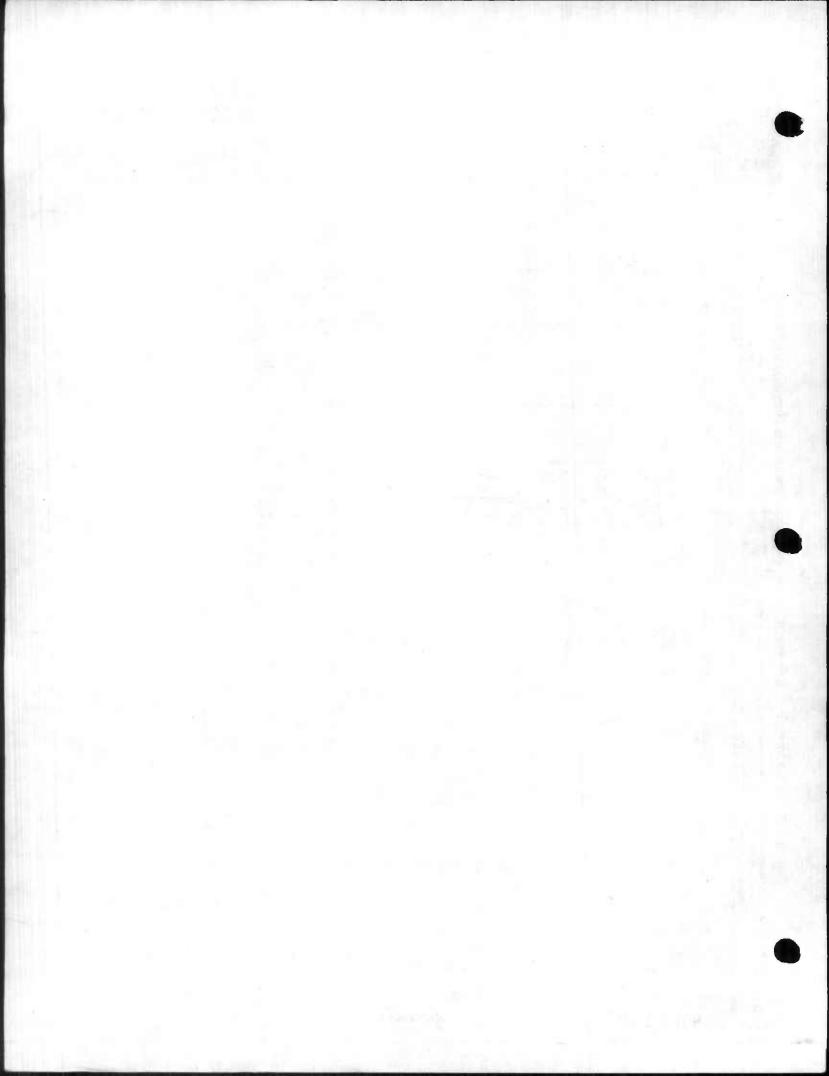
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State of Maryland / Department of Health and Mental Hygiene

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ian	1.1	Decedent a Ivenile (i									Month	Da	av	Year	3. Time	f Death	
ical	Martha Jane Foreaker										November 4				14:	-5	
iner	48	Facility Name (If not	t institution, giv	re street and n	umber)				4b. City, To	wn, or Lo	cation of Dee	th 4c	. County	ot Deeth			
	ш	Laurelwoo	d Care	Center					Elkto	n		C	ecil				
	5. 5	Social Security Numb		Sex	s. last birthday)	If Und Month:	er 1 Year S Days	If Under Hours	24 Hrs. Min,	8. Dete of B (Month, D	irth	)	9. Birthp	olece (State	or Foreig		
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	1	uel Residence of De															
	104	10a. State 10b. County 10c. City, Town or Location												1	Od. tnside (		
DIFECTO	Ma	Maryland Cecil North					t					1 Yes			2 K N		
711.0	100	e. Street and Number	r		10f. Zip			ip Code	Code			10g. Citizen of What Country?					
	1	185 Old Log Cabin Road					2:	21901 United State					es				
Funeral		Marital Status	12. Wes De	1 ☐ Yes 2 N No		Wes Dec	es Decedent of Hispanic Origin? (Spe Yas, specify Cuban, Mexican, Puerto			ecify Yes or N	lo- 14. Race - American Indian, Bleck, White, etc.						
		1 Never Merried	1 Yes														
-		3 ☑ Widowed 4 □	Divorced	Year or	Year or Detes:		1 ☐ Yas 2 ☒ No Specify:					Specify: White		e			
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90	17.	Father's Name (Firs	t, Middle, Last	)	22011				18. Mother's Neme (First, Midd		(First, Middle						
0	Н	larry Reyn	olds				Florence				Hill						
-		e. Informent's Name		Type, Print)		19b. Mailir	na Addre	ss (Street			al Route Num	ber, City o	or Town.	Stete. Zic	Code)		
	T	ohn Forea	ker / 9	Son							, Nort					100	
		a. Method of Disposit	,	7011	20b.	Place of Dispo	sition (N	eme of		Itoau	Dete				own, State	1901	
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	-	4 Donelion 5		74	orth Ea		Methodist Cemetery 8, 1999 North East,					Mary.	J				
	21. Signature of Funeral Sports Legisle 22. Name and Address of Facility Crouch Funeral Home											.and					
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	23	Ba. Part1. Entar the di shock, or heart tai	Iseese, or com ilure. List only	plications thet one cause on	caused the dea	C	27 5	South	Main	Str	eet, No	orth errest,	East	, Mai	Approxime Intervel Be Onset and	219	
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DHMH 16 Rev 6/95



JOHN

State of Maryland / Department of Health and Mental Hygiene
FORD AMEND ITEMS: #23 PART I, 27, 28A-Certificate of Death

Reg. No.

Days

3	6	1	2	-
U	U	1	E	U

**Physician** /Medical Examiner

Wilber Ford, Jr. John 4a Facility Name (If not institution, give street and number)

Month NOVEMBER 3, 1999 4b. City. Town, or Location of Death

3. Time of Death 12:38P.M.

PRINCE GEORGES HOSPITAL 5. Social Security Number

1. Decedent's Name (First, Middle, Last)

7. Age (In yrs. last birthday) Months 1⊠M 2□ F Yrs 55

CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Oct. 27, 1944

2. Dete of Death

Reg. No.

PRINCE GEORGES 9. Birthplace (State or Foreign Washington, D.C

**Funeral** Director

r 28e-f

Hygiene. other than "naturel", or flems 23s or vent, the Medical Examinar must be

Director

Funeral

by

Completed

Be

the Maryland

filed within 72 hours after

. Pages 1 and 2 should be filed viment of Haalth end Mental Hygle lant: If Nem 27 le marked other tiury or other traumatic event, in

permit. Paga Depertment of Important: If any injury or paga.

**Physician** 

/Medical

Examiner

buriel-transit

for use

signed by the a

cartificata

After this cartifical funeral director, i

To the Hospital or Attending within 24 hours after deeth. To the Funeral Director; Afte completely filled in by the fun

Physician/Medical

þ

Completed

8

Certification: To

Medical

physicien at the buriel

The lew requires that the deeth certificate be assocuted

Box 68760.

Records, P.O.

Division of Vital

Attending Physician:

21215-0020

Baitlmore, Marviand

10e State Maryland

213-42-9564

Usual Residence of Decedent

10b. County Prince George's

District Heights

10c. City, Town or Location

10d. Inside City Limits 1 No 2 No

10e. Street and Number

1914 Rochelle Ave.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

20747 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indien. Black, White, etc.

Black.

United States

Year

4c. County of Death

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

10g. Citizen of Whet Country?

Elementary/Secondary (0-12) 12

College (1-4or 5+)

Maintenance Worker

10f. Zip Code

Government

Specify:

17. Fether's Name (First, Middle, Last)

John Wilber Ford, Sr.

Theresa Brown

19a. Informant's Neme/Relationship (Type, Print) Dorothy Ford/ Mother

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 6017 Seat Pleasant Dr. Capitol Heights, Md.

18. Mother's Nama (First, Middle, Maiden Sumame)

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other p cometary, crematory or other place)
Harmony Memorial Park

20c. Location - City or Town, Stete 11/9/99 Landover, Md.

re of Funeral Service Licens

22. Name end Address of Fecility
Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Pertř. Enter the definese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

CHEST INJURIES COMPLICATING HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings availabla prior to completion of cause of death? 1 NYes 2 No

Approximate Interval Between Onset end Death

25. Wes case referred to medical examiner? 17 Yes 2□ No

5 Pending investigation

6 Could not be

Hospital: 1 ☐ Inpatient 2 NER/Outpatient 3 ☐ DOA 28b. Time of A 28a. Date of Injury (Month, Day Year) 11-3-99 11:53 M

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28c. Injury at Work? XYes 2 No

26. Place of Deeth (Check only one)

111 Penn Street, Baltimore, Maryland 21201

28d. Describe how injury occurred SUBJECT DRIVER OF TRUCK STRUCK 281. Location (Street and Number of Bural Poute Number. RGC City or Town, State) 10251 OLD LARGC

29a. Certifier (Check only one)

27. Manner of Death

1 Netural

2 Accident

3 Suicide

4 ☐ Homicide

PARKING LOT RD. LARGO, MD. 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date end place, and dua to tha causa(s) end menner es steted. 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number O.C.M.E.

NOVEMBER 4,1999

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of earth (Item 23a) (Type, Print)

THEODORE Mit 31. Date filed (Month, Day, Year) NOV 1 0 1999

32. Registrar's Signature

we

Sports

State Registrar

**DHMH 16 Rev 6/95** 

man gan

40 V 1 0 1999

State Registrar 1avil

31. Date liled (Month, Day, Year)

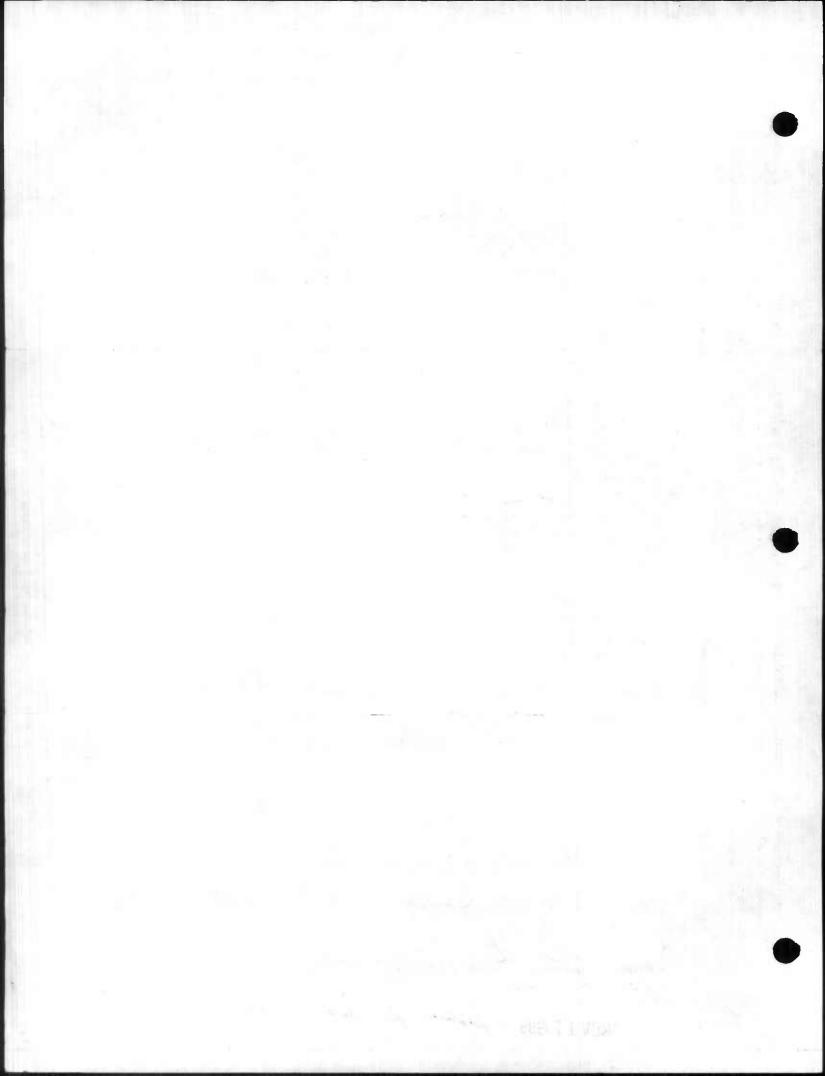
DHMH 16 Rev 6/95

10ww

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** November 4,1999 3:30PM RICHARD JOSEPH GOOSEBERRY, JR. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center La Plata Charles 5 Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Min 1₩ 2□ F Months Deys Hours Yrs. Director 218-30-3798 67 MARYT AND OCT. 4, 1932 Usuel Residence of Decedent the Merylenc 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show iner must be notified at 1 ☐ Yes 2 ☑ No MARYLAND CHARLES ROCKPOINT Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with Goose berry 13597 FURBUSH ROAD 20682 UNITED STATES Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? traumatic event, the Medical Examiner Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2X Married ò 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Yeer or Dates "naturel", Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th OYSTERMAN OYSTERING is marked other 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Peges 1 and 2 should be JOSEPH RICHARD GOOSEBERRY, SR. MARGARET ELIZABETH MIDDLETON 2 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Department of Health a important: If item 27 is any injury or other tra-JAMES PAUL GOOSEBERRY / BROTHER 13597 FURBUSH ROAD ROCKPOINT, MD 20682 Itimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State HOLY GHOST CHURCH CEMETERY11/9/99 ISSUE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funete Service Licenses

AVDIA C. THORNTON JOHNSON M00582 22. Name end Address of Facility
THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON RD INDIAN HEAD, MD 20640 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each tipe. pproximete Itervel Between Inset end Death **Physician** eu /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician end the burial-transit certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) use as t ō signed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. o Yes 2 No 3 Probably 4 Unknown Records, 9 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Was en eutopsy Completed peeu aw page 2 2 DANO 1 □ Yes 2 □ No 1 Yes certificate Division of Vital Hospital or Attending Physician: director. 25. Wes cese referred to medical Be 26. Place of Deeth (Check only one) exeminer? Hospitel: 1 Apatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: After Injury 1 Naturel 5 Pending efter deeth. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certitier Medical completely (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signeture end title and tifler 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Collins P. Sein, MD 605 East Charles Street La Plata, Maryland 20646

32. Registrer's Signature

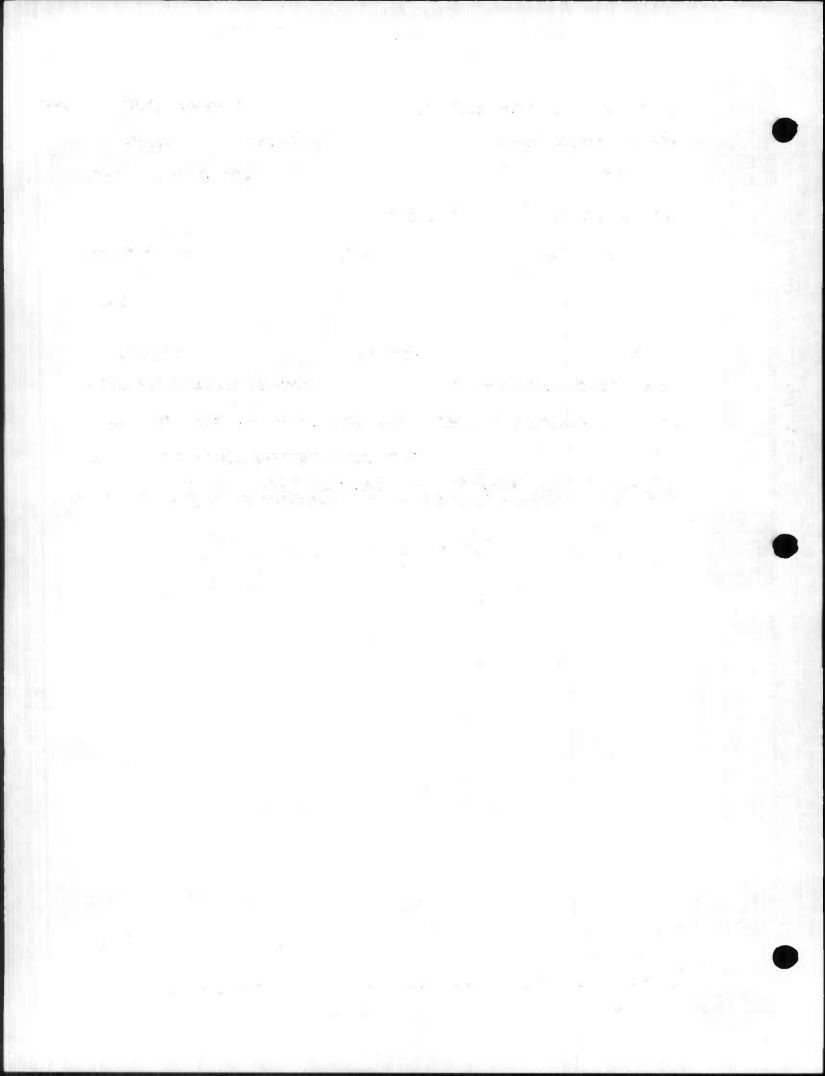
1999

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State

Registra

31. Dete filed (Month, Dev. Yeer) NOV 0 8



State of Maryland / Department of Health and Mental Hygiene QQ 36128

						Cen	tificate o	f Death		Reg. No.	) 0(	) 1 2 0
			1. Decedant's Nama (First, Middla, La	st)					2. Dete of De	eth		. Tima of Death
	Physici /Medi		William T.	Gray					Novemb	er 3, 19	Yaar 999 6	:45 PM
	Examir		4a. Facility Name (If not institution, given	a street and number	r)			4b. City, Town,	or Location of Deet			
1			7901 Pats Lane					Fort Wa	ashington	Prince	George	es
	Funeral Director		377-10-4707	Sex IĎM 2□ F	ige (in yrs. las		If Under 1 Yea Months Day	r If Under 24 F	Hrs. 8. Data of Bir (Month, Da August	th ly, Year) 25,1912	9. Birthplece Country) Virgi	(State or Foreign nia
	pur *		Usuel Rasidance of Dacedant  10a. Stata 10b. County		10c City	Town or Loc	etion				104 [	Inside City Limits
	e Maryla	ctor	Maryland Prince	Georges	, out only,		Washing	gton				1 ☐ Yes 2 ☑ No
	th with th	Funeral Director	10e. Street and Number 7901 Pats Lane				10f. Zip Code 207			U.S.A.	What Country?	
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mantel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified at once.	Completed by Funer	11. Marital Status 1 □ Naver Merried 2 □ Married 3 □ ◯ Widowed 4 □ Divorced	12. Wes Deceden Armed Forces 1  Yes 2 It Yas, Giva Yaar or Detas		13. W	/as Decedent of Yas, specify Cu ☐ Yas 2 □XN		? (Specify Yes or No uerto Rican, etc.)		e - Amaricen Ir ck, Whita, atc. w.White	ndian,
5-0	72 ho	sted	15. Decedant's E (Specify only highast gra	ducation ada complated)		16a. Deceda	ant's Usuel Occ	supation ne during most of	workina	16b. Kind of Br	usinass/Industr	ry
121	vithin Ne.	Jq.	Elementery/Secondary (0-12)	Collega (1-4or	5+)			e during most of red)			10	
12	led w		47 Fashada Nama (First 16:44a 4 an			Crema	itor	40.11.11.1	N	Cemeter	-	atory
and	be fi	Be	17. Fether's Neme (First, Middle, Last						Nama (First, Middla	, Maidan Suman	ia)	
2	J Mar marke	2	Melvin Gra			401 11 11		Ada	Ennis	01.		471
Ma	d 2 sl th an 7 ls r traur		19e. informant's Name/Ralationship ( Joseph W. Gray/so						<i>Rural Routa Numb</i> Ashington			78.)
	Heeli Heeli Heeli Heeli Heeli		20a. Mathod of Disposition	711			ition (Nama of atory or other p		Deta	20c. Location -		Steta
Baltimore,	nt of int of int of		1 ☐ Burial 2 ② Cremation 3 ☐		9						ndria,	
量	artme ortani		4 □ Donation 5 □ Other (Specification of the Specification of the Speci		metr	_	an Crema		1/4/1999	Alexai	lulla,	V A
Ba	Depar Impor		I you V.	Kalos		Ge 61	orge P. 60 Oxon	Kalas H	Funeral Hol., Oxon 1	ome, P.A Hill. MD	20745	
			23a. Part1. Enter the diseasa, or com shock, or haart tailura. List only	plications that cause one cause on each	ed the deeth. Ilna.	Do not ente	r the mode of d	ying, such es care	diac or respiretory e	rrest,	Apr	proximeta arvel Between
	Physician /Medical Examiner		Immediata Causa (Finel diseasa or condition resulting in death)	a	Dua to (or a	es a consequ	dico jence of):	prost	il e	mær	18	sat and Death
	uted d ansit	Examiner	Sequestially list and divine	b	Due to (or e	es e consequ	iance of):					
oʻ	tificete be executed ig physician end as the burial-transit		Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		Doa to (or e	oo o consequ	and ory.					
68760,	ysick	Medical	Cause (Disaasa or injury that Initiated evants resulting in daath) Last	C	Due to (or e	s e consequ	ance of):					
	ntifice ng ph	Med	resulting in daatii) Last								1	
Box	attendin for use	an/J		d							1	
	the att	sici	Part II. Other eignificant conditions of	ontributing to death	but not resuiti	ing In the un	derlying causa	givan in Part I.	23b. Dld	tobacco use co	ntribute to the	cause of death?
P.0	thet the dead by the deteched	Physician/							1 🗆	Yes 2000	3 Probably	y 4 Unknown
Ś	es the igned be de	by									T	
Record	aw requires to seen so should	Completed								an autopsy ormed?	availab	autopsy findings ble prior to etion of cause th?
	The ata h	Con							10	Yas 2 No	1 □ Ya	as 2 No
Vital	ysician: The	Be (	25. Was case rafarred to medicel axaminar?					26. Place of	Death (Check only	ona)		
of \	O io	2	1 ☐ Yas 2 ☒ No	Hospital: 1 Inpat		R/Outpatient	3LI DUA		ig Homa 5₺ Rasi	dance 6 □Oth	ar (Specify)	
E C		:	27. Manner of Deeth 1 ☑ Natural 5 ☐ Panding	28a. Dete of In (Month, D	ury 2 ey Year)	8b. Tima of injury	28c. In		28d. Dascribe	how Injury occur	red	
sio	Attending or deeth. actor: After by the fune	cati	2 Accidant Invastigation 3 Suicida 6 Could not b					☐ Yes 2☐No				
Division	tal or Attendent selfer deetled Director:	Certification:	4 Homicida detarmined	∠8a. Place of II	njury - At hom atc. <i>(Specify)</i>	a, farm, atra	at, factory, offic	:e	28f. Location ( City or To	Straat and Numb wn, Steta)	er or Rurel Ro	uta Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completaly filled in by the	edicai	29a. Certifier  (Check only ane)  (Check only ane)  1 ☐ Certifying Ph  2 ☐ Medical Example (Check only ane)	ysician: To the best niner: On tha basis and menner s	of examination	edga, daath n and/or inva	occurred at tha astigation, in my	tima, data and pl opinion, daath o	ace, and dua to tha ccurred at tha tima,	ceusa(s) and ma data and place,	annar as stated and dua to tha	t. ceuse(s)
	withir To th	×	29b. Signature and title of contillor	TA			29c. Lice	nse number		29d. Date signe	d (Month, Day,	, Year)
	7		1 / Agu	Dall			D-	17601	7	11/4/9	39	
1	(10)	i	30. Nama and address of person who	complated ceuse of	daath (Itam 2	3a) (Type, P	Print)	21-0	1.0	8926 I	Noodyar	d Rd.#201
3	0		D.J. HAI	DAK	MI	)	Cl	with	, ma	. •		20735
	Sta	te	31. Date filad (Month, Day, Year)	3 Ragis	irar's Signatur	ra 🔏		**				

494 0 5 1999 Janear B. South

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year Physician Lilly Ann Green October 31, 1999 2:55 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Hospital Baltimore, Baltimore City If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North **Funeral** Days 1 M 2 F Yrs. 578-52-6824 83 12,1916 Carolina Director Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. tnside City Limits r than "natural", or flame 23a or 28a-f ahow the Medical Examiner must be notified at 1 De les 2 No Funeral Director Prince Georges Bowie 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 10610 Excalibur Road #A407 20716 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after al Hygiene. other than "natural", or the 1 ☐ Yes 2 No If Yes, Give Year or Detas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flie Deportment of Health and Mental Hy Important: if Item 27 Is marked orther any Injury or other traumatic avent pates. Be Fred Lilly Addie Hanks Hearn Lilly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Roy Green/Husband 10610 Excalibur Rd. #A407 Bowie, Md. 20716 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location · City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 11-6-99 Clinton, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Shannan W. Blall Beall Funeral Home Shannon W. Beall M00798 6512 N.W. Crain Highway Bowie, Md.20715 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel Sepsis Zweeks diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner Obstructive Jaundice attending physician end for use as the burial-trensit that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, Klatskin Tumor Physician/Medical Due to (or as a consequence of) 88 P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Munknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy Completed hes e 2 page The certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital al or Attanding Physician: T s after death. II Director: After this certificat ed in by the funeral director, pi Be 25. Was casa refarred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Medical Certification: To 28e. Dete of Injury (Month, Day Year) 27. Mennar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pelli To the Hospital within 24 hours a To the Funeral C completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. M. Derber, RES-000 October 31, 1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Jonathan M. Gerber 600 N Wolfe St Baltimore, MD 21287 31. Date filed (Month, Day, Year) VCV 0 5 1999 12. Registrar's Signeture State Registrar

Jane & march 959 19 19

State of Maryland / Department of Health and Mental Hygiene Q 36130

Physician	
/Medical	
Examiner	

Fune Direc

permit. Pegas 1 and 2 ahouid be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglens. Important: if item 27 is marked other than "natural", or herra 23a or 28e-4 show any injury or other thaumatic event, the Medical Essenther mantle nothing as any injury or other traumatic event, the Medical Essenther mantle nothing as

Baltimore, Maryland 21215-0020

Physici /Medic Examir

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 42 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit 10+1 VA

			Ce				*		Reg. h			
1. Decedent's Name (First, Middle, L	.ast)							2. Date of E		Day	Year	3. Time of Dea
Bernard Hardy II	II							NOVE			1999	2335
4a Facility Name (If not institution, g	ive street and num	nber)				4b. City, T	own, or Lo	ocation of Dea			y of Death	
NORTH OF 2607	7 BELAIR	RD.				BEL	AIR			HARF	ORD	
214-88-4678	Sex 1 M 2 F	7. Age (In yrs. 36	last birthday, Yrs.	Months	1 Year Days			8. Date of B (Month, L ctober				place (State or For ntry) 1and
Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or L	ocation							1.	10d. Inside City Lin
		100.0	ly, Town or C	ocation								1 ☐ Yes 2 📉
Maryland Harford	1	Be1	Air						,			7 C 661 C
10e. Street and Number				10f. Zip	Code				10g. (	Citizen of	What Cou	ntry?
211 Broadview Av	renue			210	14				Un	ited	Stat	es
11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Dece Armed For 1 1 Yes If Yes, Giv Year or Da	rces? 2 No	J,S. 13.	Was Deced If Yes, spec 1☐ Yes				ecify Yes or N Rican, etc.)	lo-		ack, White, ify:	can Indian, etc. ite
15. Decedent's f	Education		16a. Dece	dent's Usue	ol Occu	pation			16b.	Kind of B	Business/In	
(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1	405 54)	(Give	b kind of wor DO NOT us	rk done se retire	ed) ad)	ost of work	ing	Ri	1110	Carp	not.
12	College (1	401 34)	Carpe	t Lay	er							et Store
17. Father's Name (First, Middle, Las	st)		,			18. Moti	her's Nem	e (First, Midd				
Bernard Hardy, J	Ir					Chri	etin	e Noto				
19a. Informant's Name/Relationship			19b. Meit	ina Address	(Street			al Route Num	ber, Cit	y or Town	n. State. 7ii	p Code)
Judy A. Dean / S  20a. Method of Disposition	rsret	20h I	Pleca of Disp			OTHE	koad	, Nort				land 2190
1 Burial 2 Cremetion 3	☐Removel from S		cametery, cre	metory or o	ther ple	ece)	Nove	ember	1.00.		Cay of 1	, 5.010
4 Donation 5 Other (Spec	ify)	Meadow	Ridge	Memo	ria	1 Par	k   8	3,1999	E1k	k Rid	lge. 1	Maryland
Signature of Funery Service United Service Uni	mplications that co	aused the deal	1	crouch 27 So	Fu: uth	Main ing, such e	Home Stre	eet, No or respiratory	arrest,			Approximate Intervel Between
23a, Pert1, Enter the disease, or co	mplications that co	ach line.	1	Crouch 27 So her the mod	Fu: uth	neral Main	Home Stre	eet, No	arrest,			Approximate Intervel Between
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23a. Pert1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions  25. Was case referred to medical examiner?	mplications that cry one cause on each one cause on each one cause on each one cause on each one cause one cause on each one cause one c	Due to (c	th. Do not en  or as e conse  or as e conse  or as a conse  sulting in the conse  28b. Time of liquy  2250  ome, ferm, st	crouch 27 So atter the mode  quence of):  quence of):  quence of):  quence of):  quence of):	Fu: uth e of dyn  A Ot We 1	meral Main Main ing, such e  26. Ple ther:  40 N iny at in	Home Strees cardiac of the strees cardiac of Death Nursing House No.	23b. Di 1[ 24a. Wa per 1ch (Check only) 28d. Describ	d tobac  Yes  Is an authormed'  Yes  Is an authormed'  (Street	topsy  Tion  A Carry  Tion  A Carry  Tion  A Carry  Tion  A Carry  Tion	ontribute 1 3 Pro  24b. Was a cool of the Cool of the	Approximate Intervel Between Onset and Death of the cause of de obsetly 4 Unix Vere autopsy findin valiable prior to ompletion of cause if death?
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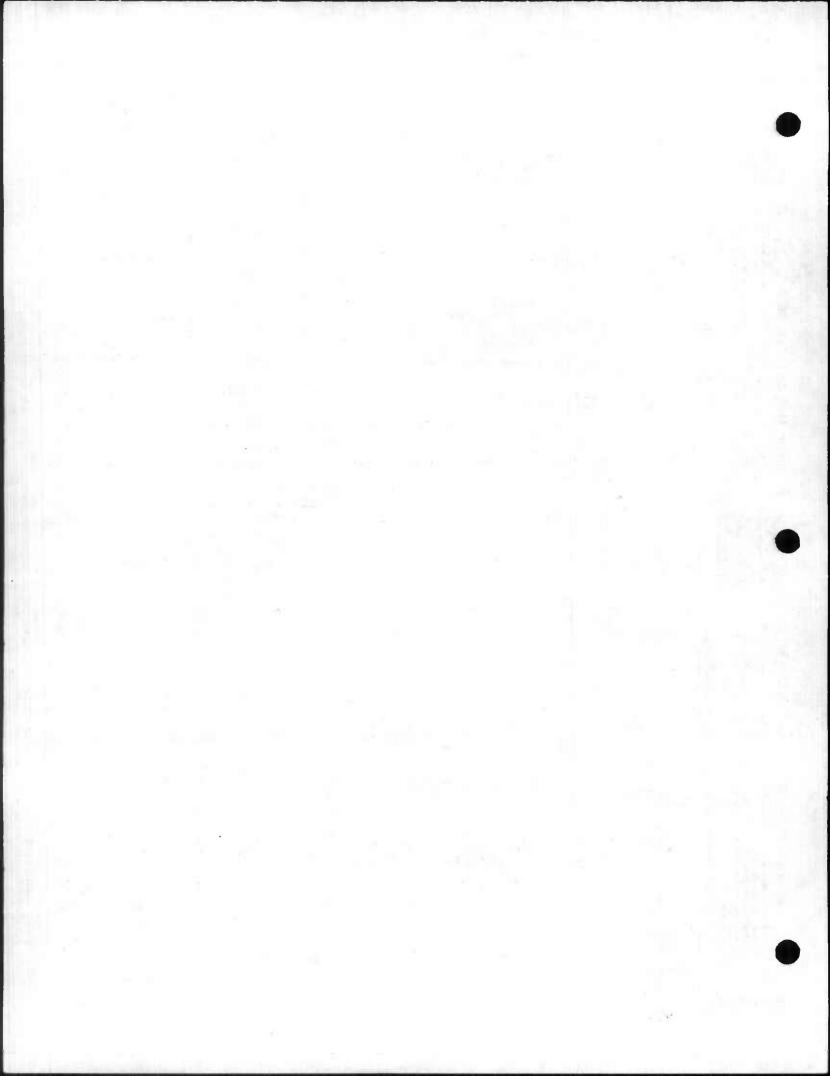
State Registrar

Josep

NOV 0 8 1999

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

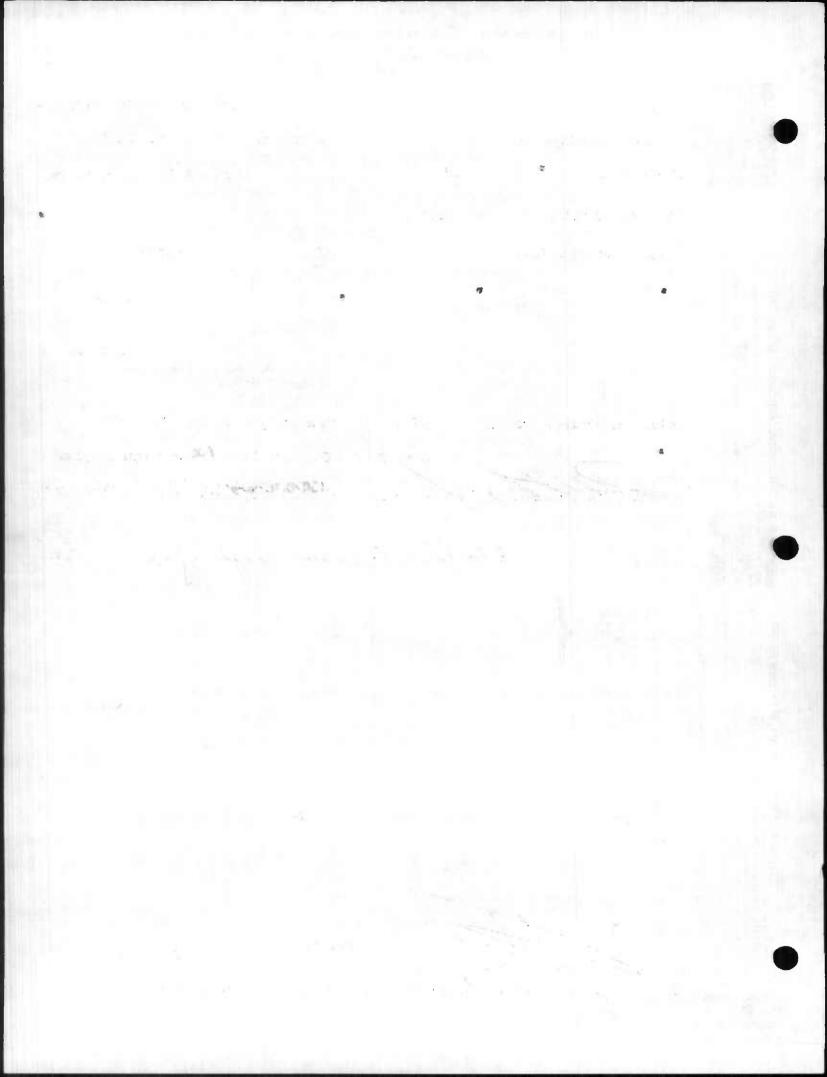


State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth November 3, 1999 **Physician** 10:55 am Nelson L. Johnson /Medical 4b. City. Town, or Location of Deeth Ac County of Deeth 4e Fecility Neme (If not institution, give street end number) **Examiner** Lexington Park St. Mary's Bayside Nursing Center If Under 1 Yeer | if Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1 M 2 □ F 58 Yrs. 213-40-8462 February 3, 1941 Director Maryland Usual Residence of Decedent with the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Charles Nanjemoy 1 ☐ Yes 2 ■ No Directo 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 13200 Riverside Road 20662 United States permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important, if lean T2 I a marked other than "natural; or items 23 any injury or other traumatic avant, the Mental Examine male. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bieck, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ■ Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Laborer Construction 11 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Lucy Johnson Lana Gaina 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 13070 Riverside Road, Nanjemoy, MD Roland R. Butler, Brother 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State Oakgrove Church Cemetery 11-6-99 Nanjemoy, Maryland 4 Donation 5 Other (Specify) 22. Neme end Address of Facility Brinsfield Funeral Home. P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 21-Signature of Funeral Se Ronald L. Thompson, D., Mor 154 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** tmmediate Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Examiner and I-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of) physician ar P.O. Box 68760. Physician/Medical Due to (or as e consequence of) as attanding p 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No signed t Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to been sig 24a. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 s 2 170 cartificata or Attending Physician: 25. Wes case referred to medicat examiner? director Be 26. Plece of Deeth (Check only one) Other: 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 1 Inpatient 2 ER/Outpetient 3 DOA this funaral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Injury Certification: After 5 Pending 1. Naturel death. 1 ☐ Yes 2 ☐ No Investigation after death

Director: A

d in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Director Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) 29a. Certifier Medical To the I 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier D19917 9 30. Name and defeas of perso Irol down (Item 23a) (Type, Print) James C. Povd. 31. Date filed (Month, Day, Year) 23415 Three Notch Rd., California, Maryland 20619 Registrar's Signature NOV 08 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Yeer **Physician** Herbert Morris Johnson, III 1999 November 6:09 am /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Civista Medical Center LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthptace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** Deys **X**XM 2□ F Months Yrs. Director 579-72-8832 43 February 7, 1956 New Jersey Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28e-f show traumatic event, the Modical Examinar mant be notified at 1 Yes 2 No Director Maryland Charles Waldorf 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20602 United States 500 Gerry Court deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No tf Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours effer on nent of Health and Mentel Hygiene. Int: If Item 27 te merked other then "naturel", or ite 1 Never Married XX Married 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced Black: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Alarm Installer Alarm Company 18 Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Barbara M. Thomas Herbert M. Johnson, Jr. 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Name/Reletionship (Type, Print) 8265 Warren Drive, Pomfret, Maryland 20675 Herbert M. Johnson, Jr./Father other Itimore, 20b. Ptace of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition Department of Important: If its eny injury or o November 9, 999 1 ABuriat 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland 20640 e, or complications that caused the deeth. List only one cause of each line. Approximete Intervel Between Onset end Deeth 23a. Part1. Enter the dishock, or heart fail Do not enter the mode of dying, such es cardiac or respiratory errest, **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner and I-transit Sequentially tist conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or thjury that initiated events resulting in deeth) Lest physician ar Box 68760 Due to (or es e consequence of): BS

Physician/Medical P Completed peen: page director, Be 10

law requires that the death certificate be executed attending p ed by the a signed by t hes he 2 The certificete or Attending Physician: this After this Certification: To the Hospital or Attendin within 24 hours efter death.
To the Funeral Director: Af completely filled in by the fu

o

Records.

Division of Vital

25. Was case referred to medical 1 ☐ Yes No 27. Menner of Death 1 Naturet 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and little of provide

31. Dete filed (Month, Day, Year)

5 Pending investigation 6 Could not be

end menner steted.

28e. Date of Injury (Month, Dey Year) 28b. Time of

Part tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t.

1 ☐ Inpatient 2 SER/Outpetient 3 ☐ DOA

1 Yes 2 No 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Piece of Death (Check only one)

24e. Wes en eutopsy

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Territying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s)

> 29c. License number 1)469

28c. injury et Work?

29d. Dete signed (Month, Dey, Year)

23b. Dtd tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were eutopsy findings eveileble prior to

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print)

Collins P. Sein, MD 605 East Charles Street La Plata, Maryland 20646

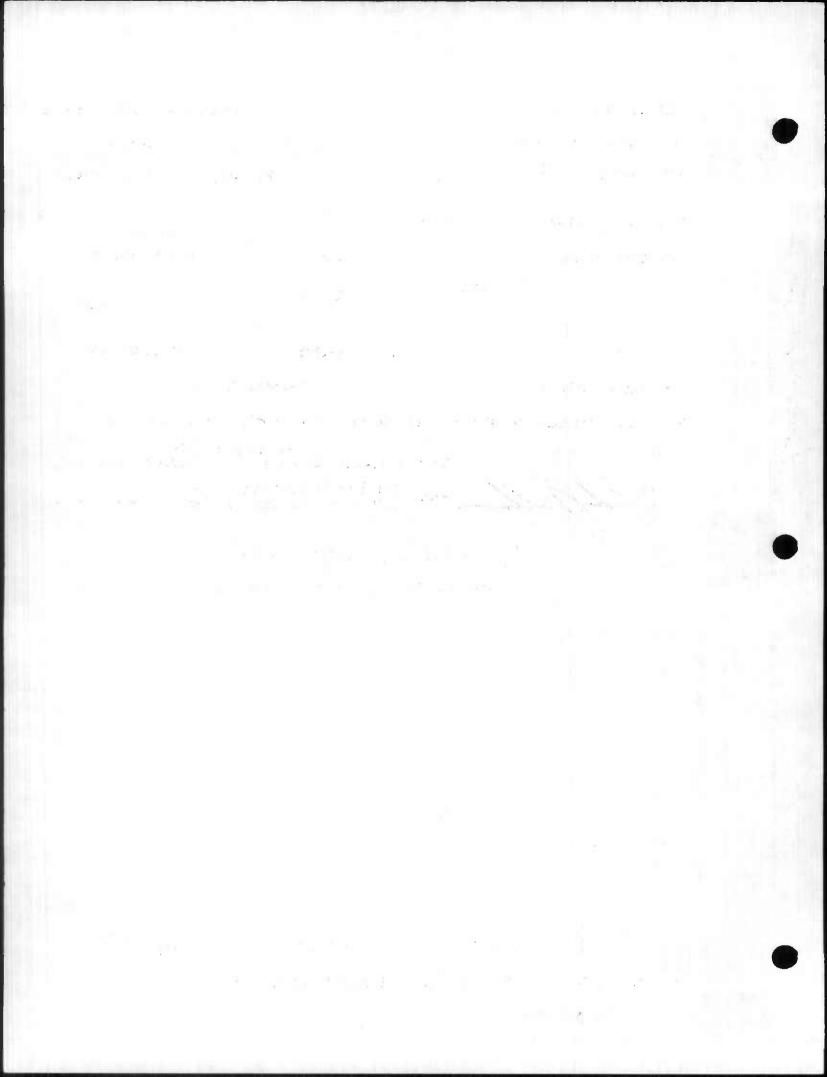
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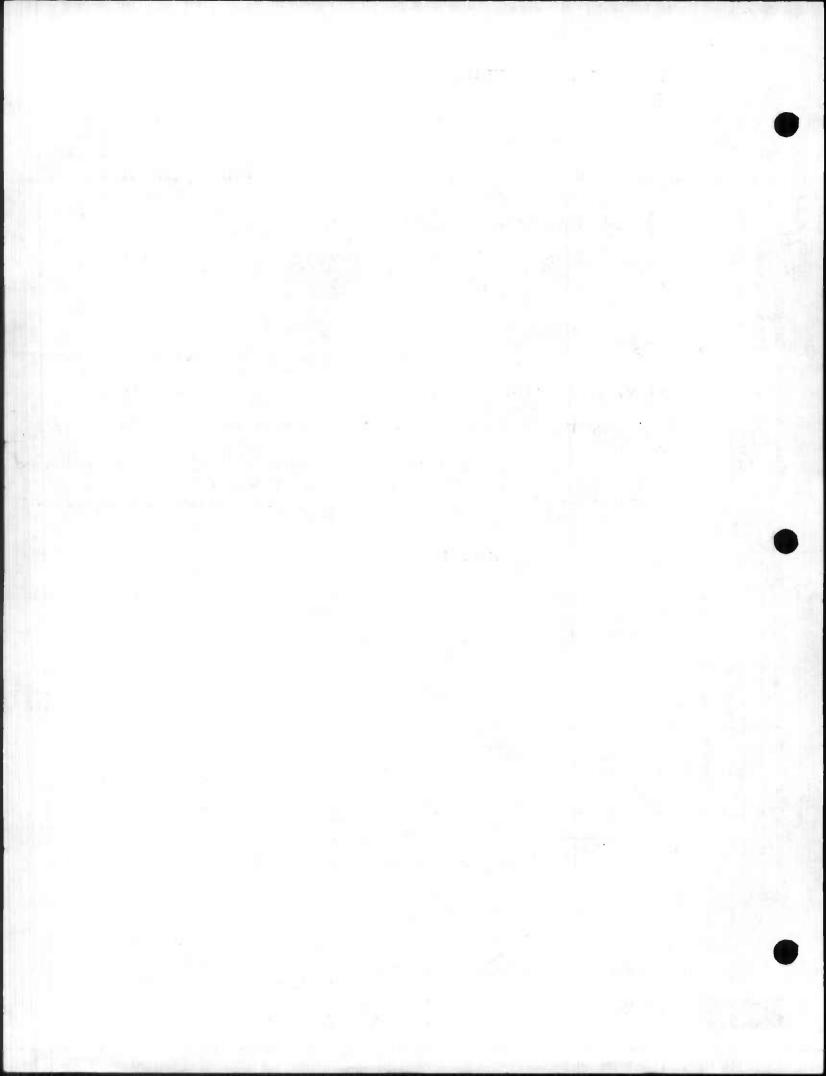
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32. Registrer's Signeture Depera

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AIWIV	OONES	AMEND#23A & 27 PER M	State of Maryla					ene g	9 36	133
	Physician	Decedent's Nama (First, Middle, Last	#)		_		2. Data of Death Month	Day	Year	ima of Death
	/Medical	DARON 48 Facility Nama (If not institution, giv	HRNE //	Jone.		, Town, or Loca	OCTOBER	30, 1		429 AM
	Examiner	PENINSULA REGION		ENTER		ISBURY			COMICO	
	Funeral Director	5. Social Security Number 6. S  2 18 - 90 - 50 72  Usual Residence of Decedent	ex 7. Age (In yrs	s. last birthday) If Unc Month		1.20	B. Data of Birth (Month, Day, -eb, 09	Year) 1968	9. Birthplace (Country) Mary	State or Foreign
yland	B W	10a. Stata 10b. County	10c. C	City, Town or Location			/		10d. In:	side City Limits
O M	sa-t softling	MD Dorch	ester	Cambri						Yes 2□No
8	r Herre 23e or 25e-f-s niner must be notifies Furneral Directo	10e. Street and Number	son Stre		2 161	2	10	g. Citizen of V	What Country?	
8	Ar ma	11. Marital Status	12. Wes Decedent Ever in Armed Forces?		edent of Hispanic pecify Cuban, Mex	: Origin? (Spec tican, Puarto Ri	ify Yas or No- can, atc.)		e - American Ind	ian,
020	by Er.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☑ No If Yas, Giva Year or Detes:		21 No Spec			Specify		
Maryland 21215-0020	No Medical in the Medical in Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Us (Give kind of	sual Occupation work done during i use retired)	most of working	1	6b. Kind of B	usiness/Industry	
2121 within	the Me	Elementary/Secondary (0-12)	College (1-4or 5+)		enter			20157	LRuctio	20
nd 2	Se ver	17. Father's Name (First, Middle, Last)		CONT		other's Name (	First, Middle, M			
ryla	To affe	19a. Informant's Name/Relationship		TONES  19b. Mailing Addre	M	argar	Re+ /	F. SA	1ith	1
Ma	27 is m or traum	Makan Re-	Jones	502 Do		treet	N	2: dge.		nd 21613
ore,	of the season of	20a. Mathod of Disposition	20b.	Place of Disposition (A cemetery, crematory of	lame of		Data 2	Oc. Localish	City or Town, Si	
Saltimore,	ndury o	4 □ Donation 5 □ Other (Specify	) St	Peters Chu	Ach Cem	etery!	64/99 C	hurch	CReek,	Marylane
Ba	any any	21. Signature of Funeral Service Licen	C. Dours		and Address of F	1 -1			11 01.1	1 21/12
		23a. Part1. Entar the disease, or comp shock, or heart failure. List only	dications that caused the dea	ath. Do not enter tha m	Jashing oda of dying, such	as cardiac or			Makyla	nd allow eximata val Between
	ysician ledical	Immediate Cause (Final								t and Death
	aminer	disease or condition resulting in death)	a. SEIZURE D	I SORDER	ก-					
2	st sliner		b							- 9
58760,	lcian end burial-transit ai Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initialed events	Due to	(or as a consequence of	f):				1 1	
68760,	physician the buria	Cause (Disease or injury that initialed events resulting in death) Last	C. Dua to (	(or as e consequence o	<b>()</b> :					
Box 6	~= •	-	d							
B. B	the attended for a	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlying	cause given in P	art I.	23b. Did tob	acco use co	ntribute to the c	ause of death?
P.O.	5° 5						1□ Ye	2 □ No	3 Probably	490nknown
Records,					<del></del>		24a. Wes an		24b. Wara au availabla	topsy findings
eco law re	page 2 should						perform	eur	completi of death	on of cause
		25 M					199 Yes		1@Yas	2□ No
of Vitai	I director	25. Was casa refarred to medical axaminer?  1 No	Hospital: 1 ☐ Inpatient 29	ZNER/Outpatient 3	Other		Check only one  5 Resider		ar (Specify)	
E 2	her the	27. Manner of Death  1 🖾 Natural	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28	d. Describe hov			
Division or Attending	at Director; After tied in by the funers	2 Accident investigation 3 Suicide 6 Could not be		home farm street fact	1 Yas		f. Location (Stre	et and Numt	per or Rural Rout	e Number.
DIV	d in b	4 Homicide detarmined	building, etc. (Spec	ily)	ory, ornou		City or Town,	State)		
Division To the Hospital or Attendition of Attendit	To the Euroral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)  1□ Certifying Phy 2□ Medical Exam	reician: To the best of my kn iner: On the basis of examin and manner stated.	nowledga, death occurre nation and/or investigation	d at the time, date on, in my opinion,	and place, and death occurred	d dua to the car at tha time, da	use(s) and ma ta and place,	anner as stated. end dua to the c	ause(s)
To the	To the	29b. Signature and titla of certifier	13/	2	9c. License numb				d (Month, Day, )	
		> 2	192		0.C.	M.E.		OCTORE	ER 30, 1	999
		30. Nama and address of person who of David Fowler, M.		om 23a) (Type, Print) Penn Stree	t, Balti	more, M	aryland	21201		
	State	31. Data filed (Month, Day, Year)	32. Fegistrar's Sign	nature						



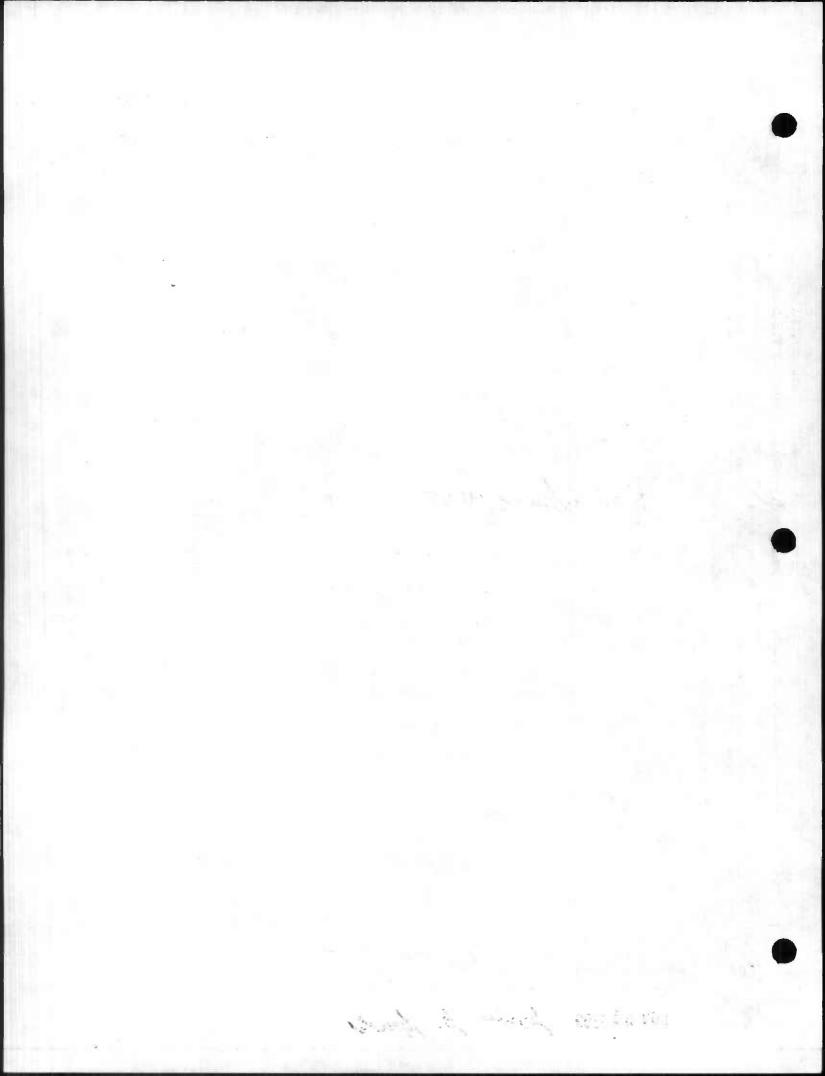
۱	Decedent's Nar	ma (First, Midd	de, Last)	)							2. Data of D		Voo	3. Time of I
l	E11	les Le	e K	Corneg	ay						Novem	ber 2,	1999	11:50
1	ta Facility Name	(If not institution	on, giva s	street and nu	u <i>mber</i> )				4b. City	, Town, or L	ocation of Dea	ath 4c. Co	unty of De	eath
	VA MEDIC		TER,	FORT	HOWA	ARD MD	210		1	RT HOV			LTIMO	DRE
40	5. Social Security	Number	6. Sex	( 1M 2□F	7. Aga (	In yrs. last bir		If Under 1 Ye Months Da		ider 24 Hrs.	8. Date of B	lirth Day, Year)	9. B	irthplaca (State or Country)
Ļ	230-50-6 Usuel Residence					74	Yrs.				/-12	-25	Way	yne Cty.,
H	10a. State	10b. Count	У		1	I0c. City, Tow	n or Loc	cation						10d. tnside City
7	/irginia					Alexa	ndri	a						1 🗆 Yas
H	10e. Street and Nu	umber				711CAG	IIIII	10f. Zip Cod	le .			10g. Citizen	of What C	Country?
	8423 Min	na Loma	Ct.	4					2309					tates
H	11. Maritel Status			12. Was Dec	cedant Evi	ar in U,S.	13. V	Vas Decedent Yes, specify (	of Hispanic	Origin? (Sp	pecify Yes or N		Race - Am	merican Indien,
	1 Navar Mar	rried 2 Me	rried		2 □ No						Rican, etc.)		Black, Wh	hite, etc.
	3 Widowed	4 Divorce	id	If Yas, G Year or I	live Dates:		1	☐ Yes 2☐	No Spec	city:		Sp	ecity: B	lack
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L	12							Supervi					vate	
	17. Fethar's Nama		, Last)						18. M	other's Nem	e (First, Midd	le, Maiden Sui	name)	
	Willie									essie				
	19a. Informant's N							g Address (Str						, Zip Code)
L		ha J. N	1ajo1	r/Daug				Alameda		Alexa		_	2309	T 0
1	20e. Method of Dis	isposition 2 DCremation	3 <b>⊠</b> R	emoval from	n State	cemate	ry, crem	sition (Name of natory or other	place)	i h	Dete			or Town, State
L	4 Donation	5 Other (	Specify)			Durn		Family						N.C.
1	21. Signature of F	uneral Service	e Licanse	98			22. A	Name end Ad Lexande	dress of Fi	Pope	Funera	1 Homes	3	
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DHMH 16 Rev 6/95

AKA: Kornegay, Elles

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** DONALD EDWIN 6:10 AM Leedom NOU. /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number, 4c. County of Deeth 4b. City, .

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

July 19, 193 Examiner HOSPITA (L NION If Under 1 Year Months Days 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 10M 20 F 68 218-28-4905 Yrs. Director Usuel Residence of Decedent the Menyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits I is marked other than "natural", or itema 23a or 28a-f show innumetic event, the Modical Examiner must be notified at 1 Yes 2 Tho CCCI Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? DEADER ROAD 2192 U.S.A Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Insportant if them 27 is merked other than "natural", or files any injury or other traumetic event. the Medical Exerci-1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 21 No Baltimore, Maryland 21215-0020 WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9Th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be HAIVE-12. Leedom WALTHER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 399 Leedom-Wife DEAVER RUAD -ELKTON MD 21921 EUELYN 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Gee FUNCIAL 23e. Pert1. Enter the disease, or complications mat caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediete Ceuse (Finel 30 mun disease or condition resulting in death) reile myour of Examiner Examiner perforati Colon ettending physicien end for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initioted events resulting in death) Lest Due to (or es e consequence of) Premueou. Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or es e consequence of): COPD cepsis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? this certificete has 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice 25. Wes case referred to medical Be 26. Piece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homiclde 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) wi chir Han MI) D04823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UZH Elkton

State Registrar

JUI CHIH 31. Date filed (Month, Day, Year)

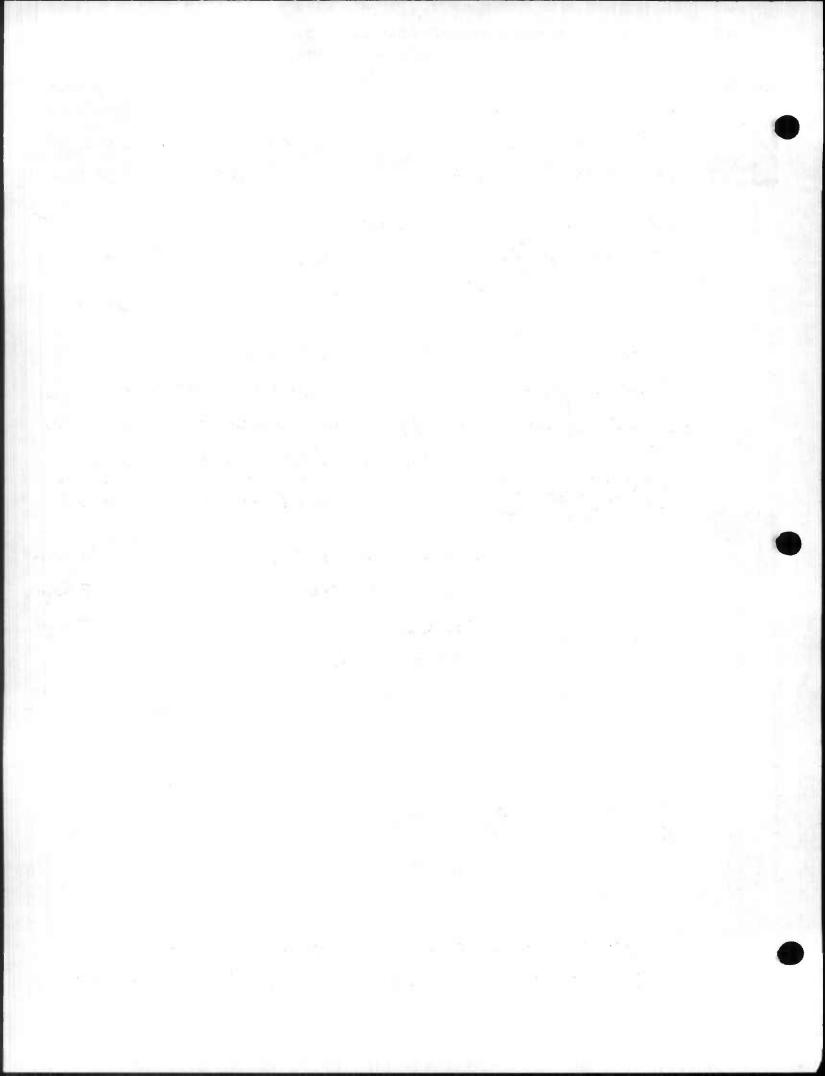
NOV 0 8 1999

32. Registrer's Signeture

West

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day 3 3. Time of Deeth **Physician** Month Richard Leroy LaPointe Nevember 0333 /Medical 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, giva street end number) 4c. County of Daath **Examiner** Union Hospital of Cecil County Cecil Elkton Hours Min. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foraign Country) **Funeral** Hours Min. (Month, January 14, Deys 1**X** M 2□ F Yrs. Director 214-92-3480 38 1961 Delaware Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil Elkton 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of Whet Country? 37 Pine Grove Lane 21921 United States death Funeral 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Haalih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or thei any injury or other traumatic event. Its Madical Exercises 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Spacify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Never worked n/a 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Robert G. LaPointe Virginia L. Bush 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 37 Pine Grove Lane, Elkton, Maryland 21921 Virginia L. Adams/ mother 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State West Chester, 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris and Company 11/4/99 Pennsylvania 21. Signeture of Funerel Service Licensaa 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 ucher H Donas ، بھ 23a. Pert1. Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Ischemic burial-trensit requires that the death certificate be asscuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Last physician s the burial NON Insulin Dependent Dinbeter P.O. Box 68760. Physician/Medical Due to (or as a consaquance of): jo ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be dete Seizures Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed DOWN'S SYNDRONE pega 2 2 1 No 1 Yes 2 10 No After this cartificata Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) To the Hospital or Attending P? within 24 hours effer deeth.
To the Funeral Director: After the completaly filled in by the funere 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Medical Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the causa(s) end menner as steted.

2 Medical Examiner: On tha bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner steted. 29a, Certifier 29b. Signature and titla of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) M.D. November 4,1999 D00477111 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar DANG GAR-EL 31. Data filed (Month, Day, Yaer) NOV 0 5 1999 32. Registrer's Signature

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State of Maryland / Department of Health and Mental Hygiene

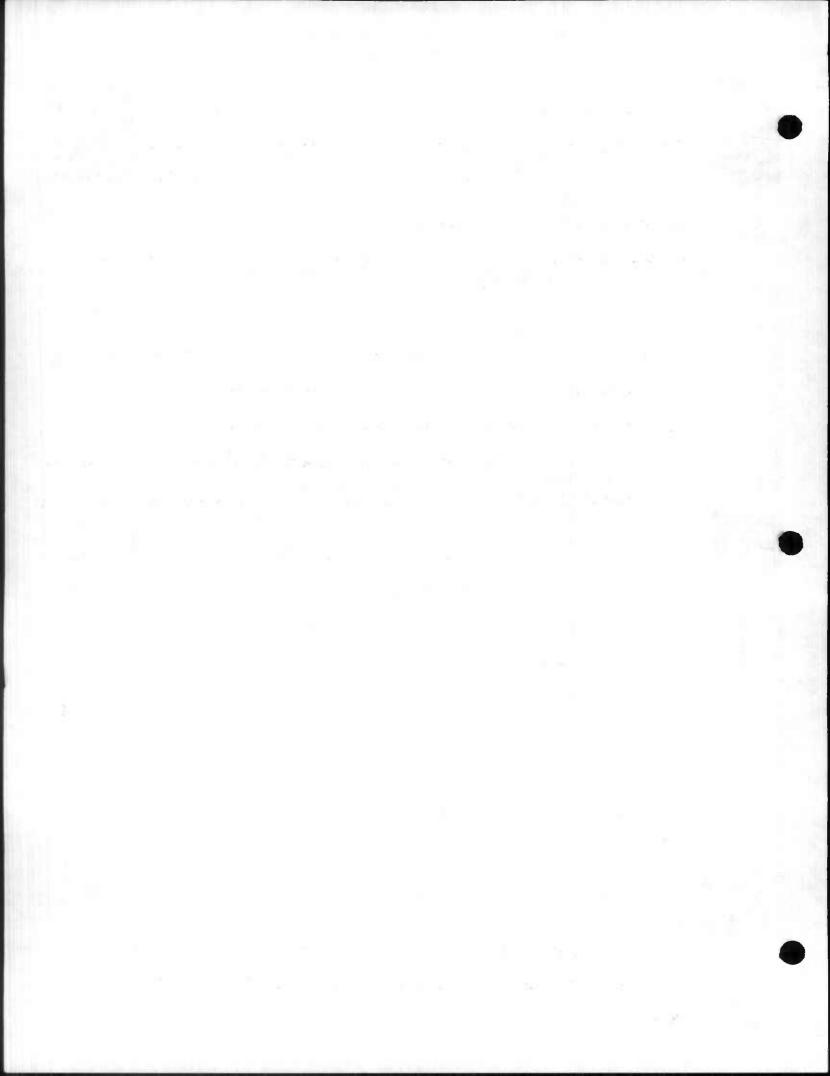
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month Day Yeer **Physician** 0021 Margaret Marie Meekins NOUEMBER 1195 /Medical 5 4a. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Union Hospital of Cecil County E1kton Ce

If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. (Month, Dey, Year) Cecil 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** Months Deys 1□M 2\ F Yrs Director 235-58-3111 61 November 14, 1937 West Virginia Usuel Residence of Decedant filed within 72 hours after death with the Mendand 10e. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Examiner must be notified at Directo 1 Yas 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 13 Manassas Drive 21921 United States Funeral 12. Wes Decedent Ever In U,S. Armad Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - Americen Indian, Black, Whita, etc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 10 Waitress Elkton Moose Lodge permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, 2008. 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumame) Be 2 Lawrence Meadows Phoebie Bryant 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Eugene L. Meekins / Spouse 13 Manassas Drive, Elkton, Maryland 21921 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cramation 3 ☐ Removel from State North East Methodist Cemetery 9, 1999 North East, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name end Addrass of Fecility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Batwaen Onsat end Death Physician /Medical Immediete Cause (Final m faction 2 hu disease or condition resulting in death) ciente my ocend Examiner Due to (or as a consequence of): Examiner 10 yes Hypertersion physician end s the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate ceusa. Entar Undartying Causa (Diseesa or Injury that initiated avents resulting in death) Lest Due to (or as a consequence of): Per fend værgel P.O. Box 68760, Physician/Medicai the Dua to (or as e consequança of) 98 attending p signed by the a Pert II. Other significant conditione contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ cate hes been significant pege 2 should b 24b. Ware eutopsy findings avellable prior to Completed 24e. Wes an autopsy performed? completion of ceuse of deeth? 1□ Yes 2□Ne After this certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was casa referred to medical 26. Pleca of Daath (Check only one) exeminer? Hospitel: 1 ☐ Inpatient 2 ★ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 ₩ funeral Certification: 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Panding investigation 1 ANatural i or Attendin efter death. Director: Aft 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street end Numbar or Rurel Route Numbar, City or Town, Steta) 4 ☐ Homleida To the Hospital o within 24 hours of To the Funeral D 1 Certifying Phyaician: To the best of my knowladga, daeth occurred at tha tima, data and place, and due to tha causa(s) and mannar as steted.
2 Madical Examiner: On the basis of axamination end/or investigation, in my opinion, daath occurred at tha tima, data and place, end due to tha causa(s) end manner stated. Medicai 29a. Cartifier (Check only one) 29b. Signature end title of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) 5/94 Hei Chil Han MD D04853 30. Name end eddrass of person who complated cause of death (Itam 23e) (Type, Print) 12 muino st, Elkfon Hd 21921 CHI 223 HSU West 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State

DHMH 16 Rav 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

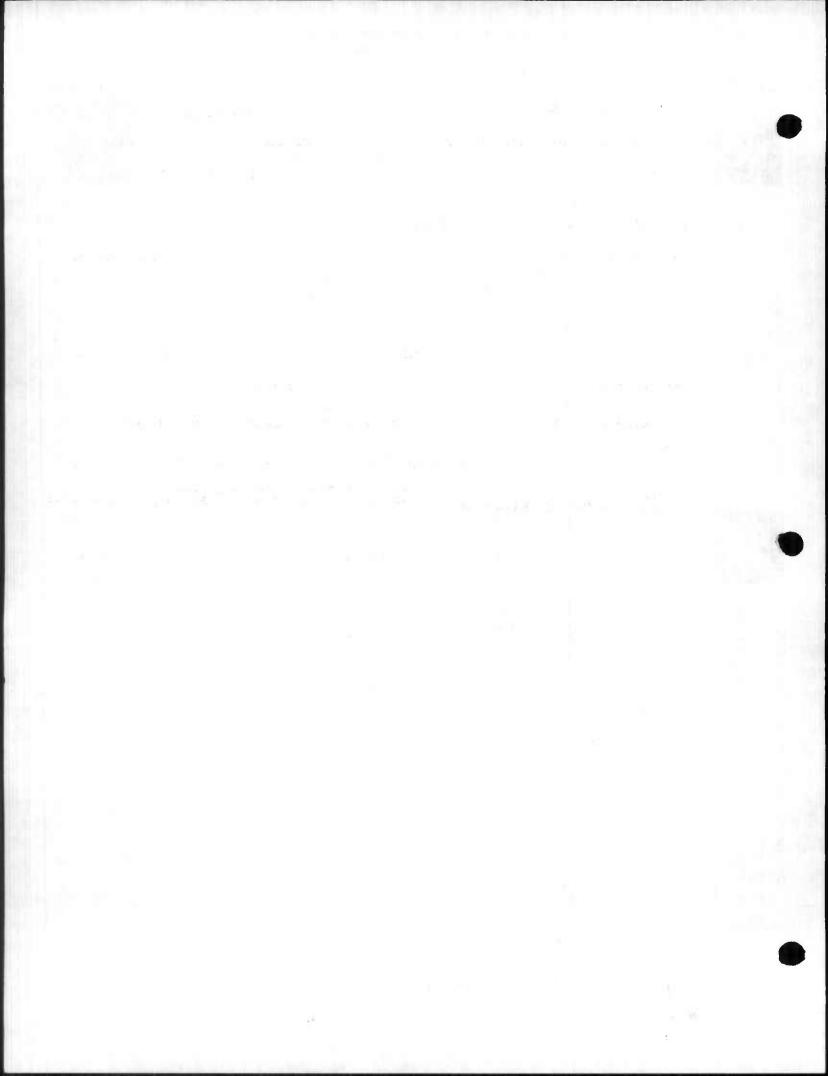
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** John Eugene Manning 4b. City, Town, or Location of Death 4c. County of Deeth 0902 /Medical 4e. Facility Name (If not institution, give streat and number) **Examiner** Union Hospital of Cecil County Elkton If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 125M 2□ F 218-05-5448 Vrs Director 82 October 21, 1917 Delaware Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 215 Maloney Road 21921 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yaar or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: If item 27 is merked other then "natural", or fire any injury or other traumatic svent, the Medical Examinations once. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 🏗 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Manning Emma Reed 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annabelle Manning/ wife 215 Maloney Road, Elkton, Maryland 21921 20b. Place of Disposition (Nama of Gilpin Manor 20e. Method of Disposition 20c. Location - City or Town, State 1 Bunai 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Memorial Park 11/5/99 Elkton, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Fecility Hicks Home for Funerals, P.A. 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 103 West Stockton Street, Elkton, Maryland 21921 Approximete Intervel Between Onset end Deeth Physician Multi, Organ Failure

Infections Endo Carditis

Due to (or as a consequence of): /Medical Immediate Ceuse (Final Week diseese or condition resulting in death) Examiner Examiner sician and burial-transit The lew requires that the deeth certificete be executed Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest ar dio my opathy
Due to (or as a donsequence of): P.O. Box 68760, rears Physician/Medical the Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Dementio of Alzheimer Type 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed to Records, þ Renal failure 24b. Were eutopsy findings eveileble prior to completion of ceusa of death? Completed 24a. Wes en eutopsy performed? 1□ Yes 2២No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 □Inpatient 2 □ ER/Outpetlent 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28e. Deta of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident invastigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signetura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) Jackely 5 MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 118 North ST, Suit 313, Elban MD 2/92/ VD S.S. SACHDEN MD. 32. Registrer's Signature 31. Data filed (Month, Day, Year) NOV 0 5 1999



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#1 perPhyG781 3/3/2000 EW Reg. No. 2. Dete of Deeth NOVEMBER 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 11 Dey 05 Yeer 99 11:30 AM Helen Pauline Methany Metheny 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Waldorf Charles 531 University Drive If Under 1 Year | If Under 24 Hrs. f Birth b, Dey, Year) 9. Birthplece (Stete or Foreign Country) 09, 1920 West Virginia 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Months Deys Hours 1□M 2\ F Yrs. 234-20-5037 78 Nov Usual Residence of Deceden 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Charles Waldorf 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 531 University Drive 20602 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coltege (1-4or 5+) Government Book Keeper/Secretary 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) MacDonald Keeney Mamie Stanley Keeney 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Judith K. Lindley/daughter 531 University Dr. Waldorf, MD 20602 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removel from Stete 11/10/99 Belle, West Virginia Witcher Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00817 22. Name end Address of Fecility Arehart-Echols Funeral Home, P.A. 23a. Pert1. Enter de diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Apprinted the feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or es a consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

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permit. Pages 1 end 2 should be file Deportment of Health end Mentei Hy, Important: If flem 27 is marked othe any injury or other traumatic avent, pages.

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Division of Vital Records, P.O. Box 68760,

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Examiner Physician/Medicai A

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certificate

• Hospital or Attending Physician: 24 hours efter deeth. • Funeral Director: After this certifica

To the Hosp within 24 ho To the Fune completely fi

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

completion of cause of deeth? 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.
2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner stated.

29b. Signature and title of certifier

25. Was case referred to medical exeminer?

5 Pending investigation

1 | Yes 20

27. Menner of Deet

1 Naturel

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

29d. Date signed (Month, Day, Year)

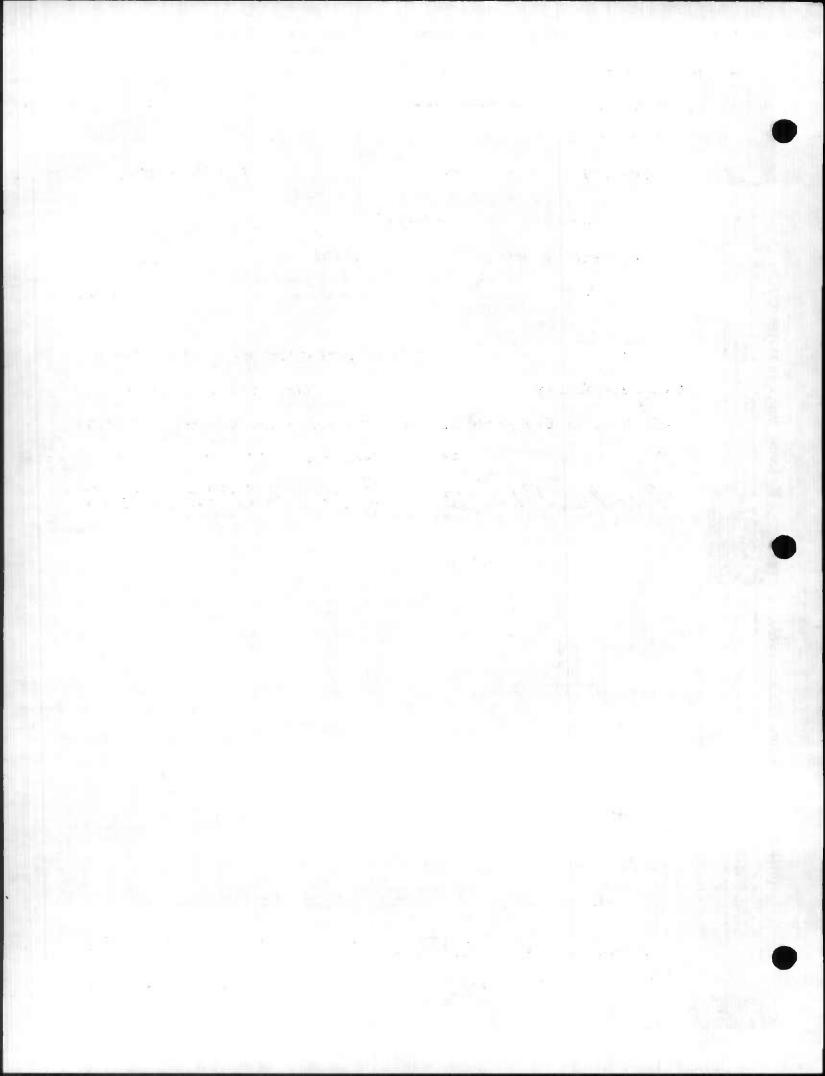
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

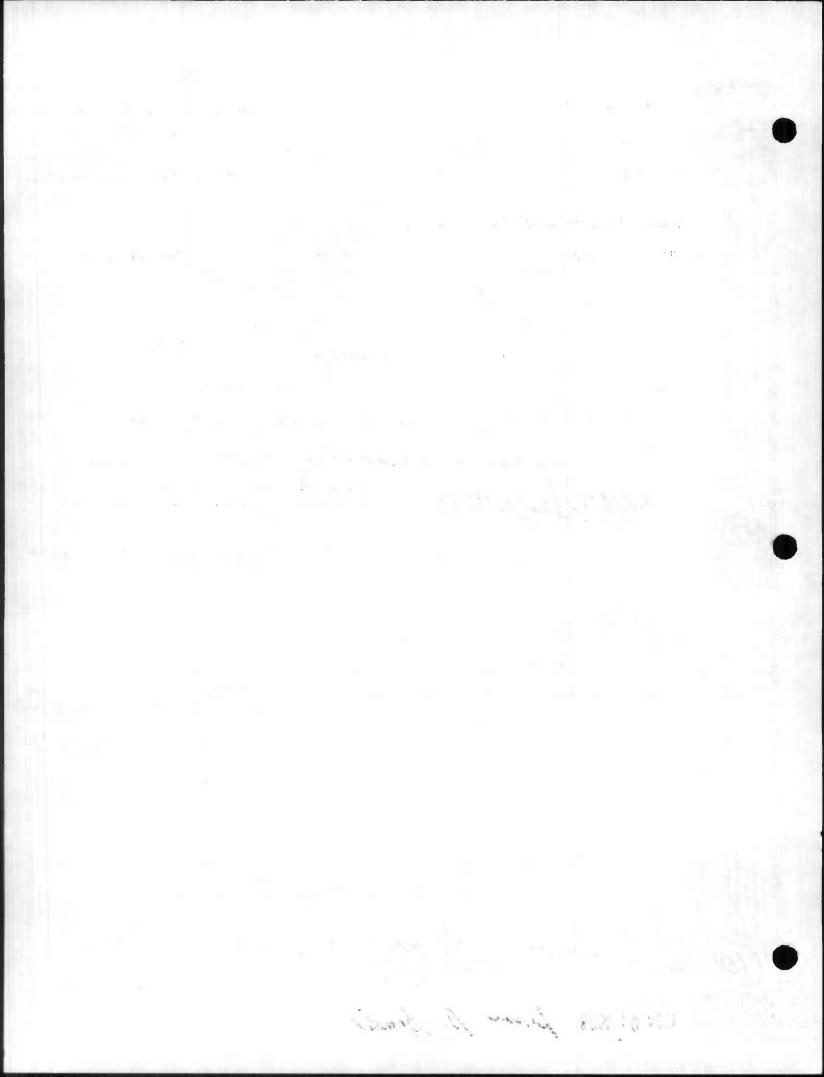
State Registrar

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31. Date filed (Month, Dey, Yeer) NOV 0 9 1999 32. Registrer's Signature



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al	4a Fecitity Neme (If not institution, give					th City Town o	November Location of Deat			8:30am	
r	Southern Marylan		1			Clinton		Prince		rge's	
	5. Societ Security Number 6. Sec. 578-54-9458 11 Usuet Residence of Decedent	ex 7. Age ☑ M 2☐ F	(In yrs. lest b	Yrs. If Under Months	1 Year Deys	if Under 24 Hi Hours Mi				otte, N.C.	
1	10a. State 10b. County		10c. City, Tox	wn or Location					10	d. Inside City Limits	
ខ្ន	Maryland Prince Go	eorge's	Sui	tland						1 ☑ Yes 2 ☐ No	
Directo	10e. Street end Number		561	10f. Zip	Code			10g. Citizen of V	/hat Count	ry?	
2	3115 Lassie Ave.			2	2074	6		Unite	l Sta	tes	
	11. Marital Status  1 Never Merried	12. Wes Decedent En Armed Forces? 1 ☐ Yes 2 図 Not If Yes, Give Yeer or Detes:		13. Was Deced			(Specify Yes or No erto Rican, etc.)	Btec	- America k, White, e	tc.	
Ì	15. Decedent's Ed (Specify only highest great		166	Decedent's Usua (Give kind of wo	al Occup	etion during most of w	rorkina	16b. Kind of Bu	siness/Ind	ustry	
no induitor	Elementary/Secondary (0-12)	Coltege (1-4or 5+	-)	(Give kind of wo				Private	2		
	47 Fashada Nama (First Stiddle 1 ant)	l		Techni	Lcia		ame (First, Middle				4
	17. Fether's Neme (First, Middle, Last) Frank James					Ruth	Mille		9)		
	19a. Informent's Neme/Relationship (7	vne Print)	10	b. Meiling Address	Street				State Zin	Code)	
	Lorraine Miller			3115 Lass						0006)	I
	20e. Method of Disposition			of Disposition (Ner			Dete	20c. Location -	City or Tov	vn, Stete	
1	t Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ncoln Cer			11/8/99	Suitla	d M	d	Ì
-	21. Signeture of Funeral Servica Lice		LT.						id, M	α.	
	Valor	N/	0				pe Funera				
-	23a. Part I. Enter the disease, or comp shock, or heart failure. List only o	incation that caused t	the deeth Dr				ike/Fores			20747 Approximete Intervel Between	
Examiner	tmmediate Ceuse (Finel diseese or condition resulting in death)	e. Mes		consequenca of):	6	1005	are	Cance		4 zeors	
	Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or es e	consequenca of):					i		7
Income in a second	that initiated events resulting in deeth) Lest	d	ue to (or es e	consequence of):							
-	Pert II. Other significant conditions co	entributing to death but	not resulting	in the underlying o	ause giv	ren In Pert I.	23b. Did	I tobecco uee cor	tribute to	the cause of death?	-
							1	Yes 2☑No	3 ☐ Prob	ably 4 ☐ Unknown	
							24a. We: perf	s en eutopsy ormed?	eve	re eutopsy findings Itable prior to apletion of cause leath?	1
							1 🗆	Yes 2 No	1□	Yes 2□ No	
1	25. Was case referred to medical examiner?					26. Plece of D	eeth (Check only	one)			
0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/C	-		4 LI Nursing	Home 5 ☐ Res	idence 6 Oth	er (Specify	)	
	27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigetion	28e. Date of Injury (Month, Dey	Year) 28b.	Time of Injury M	28c. fnjui Wor 1□	y et rk? Yes 2 □ No	28d. Describe	how Injury occur	ed		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injur building, etc.	ry - At home, ( (Specify)	arm, street, fectory	y, office		28f. Location City or To	(Street end Numb own, Stete)	er or Rural	Route Number,	
edical		valcien: To the best of liner: On the bests of end manner state	exeminetion e								
Me	29b. Signeture and title of certifier	(.)	λ	290	c. Licens	se number		29d. Dete signe	d (Month, L	Dey, Year)	-
	13NN	- (N	S	N	(	396	91	1//1	119	9	
											s
1	30. Neme end eddress of person who c	completed cause of de	ath (Item 23a)		)	1 ^		12.4	1 0	-5.1°C	1
te	30. Name and address of person who comes address of person who comes address of pe	completed cause of dec	- 441		Brav	ich Aux	1. Temp	a Hills, r	nd. 2	MA8	



State of Maryland / Department of Health and Mental Hygiene 9 36 14 1

					Certi	ficate o	f Death		Re	g. No.	0	0 14	1
		1. Decedent's Nama (First, Middle, Last	)						2. Data of Death		Vana	3. Tima o	of Death
Physic /Med		James Her	ry l	Moore					Month Novembe:	Day r 1, 19	Year 999	8:15	am
Exami		4a Facility Nama (If not institution, giva					4b. City, To		cation of Death	4c. County			
		513 71st Street					Seat	Plea	sant	Princ	ce Ge	orge !	S
Funeral		Social Security Number     6. Sa		n yrs. last birl		If Under 1 Ye		24 Hrs. Min.	8. Data of Birth (Month, Day,			olaca (Stata	
Director	Ц	579-52-0043 Usual Rasidence of Decedant	MM 2□F 5	88	Yrs.	workins Day	ys Hours	IVINI.	Dec. 16,	1940	Pen	nsylva	ania
ylenc Maria		10a. Stata 10b. County	10	c. City, Towr	n or Locat	tion					1	Od. Inside C	City Limits
Me T	tor	Maryland Prince	George's	Sea	at P1	leasani	-					1 🗓 Yes	2 No
r 284	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	What Cour	ntry?	
3a o	D	513 71st Street				20	743			U.S.A			
deett deett	Funeral	11. Marital Status	12. Was Decedent Eva	r in U,S.	13. Wa		, , ,	gin? (Spe	cify Yas or No- Rican, atc.)	14. Rac	e - Americ	can Indian,	
d 21215-0020 filed within 72 hours after deeth with the Meryland Hygiene. ther than "natural", or frems 23s or 28s-f show out, the Medical Exeminer must be notified at	by	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yes 2 ☒ No II Yas, Giva Yaar or Dates:			es, specify C			Rican, atc.)	Specify	k, White, Whi		
72 hours	Completed	15. Dacadent's Edu	cation	16a.	Deceden	t's Usual Oc	cupation	A ad	1	6b. Kind of Bu	usiness/în	dustry	
21.5 hin 7	ple	(Specify only highast grad Elamentery/Secondary (0-12)	College (1-4or 5+)		lifa. DO	NOT use ret	ne during mos ired)	t of workii	ng				
id 212. filed withir Hygiene. ont, the M	E O	8	O0110g0 (1 401 04)		Glas	s Mecl	nanic			Thomps	on's	Glass	co.
and 212 be filed with hel Hygiene. d other than event, the	BeC	17. Father's Name (First, Middla, Last)					18. Mothe	er's Nama	(First, Middle, M	aiden Suman	18)		
Maryland 2 2 should be filed end Mentel Hygi is marked other summitic event, is	ToB	Thomas Walker M	oore				Elsi	e M	ae Mast	erson			
Maryland d 2 should be file h end Mentel Hy 7 is marked oth traumatic event	-	19a. Informant's Name/Ralationship (T)	rpe, Print)	19b.	. Mailing	Addrass (Stre			Routa Number,		State, Zip	Code)	
CENL	17	Charlotte I. Moor	e - Wife	51	13 71	et St	reet S	loat	Pleasant	Mary	1 and	207/	. 3
은 - 보호등		20a. Mathod of Disposition		20b. Place of	Dispositi	on (Nama of			Data 2	Oc. Location -			13
Baitimore, pemit. Peges 1 at Department of Hea Important: if them: any injury or othe once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			ngtor		onal Ce	emețe	/06/99 ry	Suitla	nd, l	Maryla	and
Dean permit popular important in popular in		21. Signature of Funeral Sarvice Licans	Harch-	males	Gas	sch's	ress of Facilit Funeral timore	1 Hon	ne, P.A.	ttsvill	le. M	D 20	781
		23a. Part1. Entar tha disaasa, or compl shock, or heart faiture. List only o	ications that caused the	death. Do							, , ,	Approxima Interval Be	ite
cete be executed physicien end in physicien end in the burist-transit unit	al Examiner	resulting In death)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	) Due	a to (or as a c	conseque	nce of):			na, sta	J -	1		
GOX 68/6U, eith certificate be ex attending physicien for use as the buria	n/Medical	rasulting in death) Last	Due	to (or as a c	onsequer	nce of):							
BOX deeth cer attendir	Cla	Part II. Other significant conditions con	stable time to depth but a	na na na Min na in	the conde		nives in Best I		225 Did tob	acco use co	maniferato a	a the sause	ad death?
that the de detached	Physician/	Seps is	itributing to death but he	ot resulting in	i ma unoe	arrying causa	given in Pert i	•	1 <b>2</b> [Ye			bably 4	
ecords  ew requires us been sign 2 should be	Completed by								24a. Wes en		av co	ara autopsy vailable prior empletion of death?	to
The The page	5								1 ☐ Yas	2 1 No	1[	Yas 2	No
ysician: The security of the second director, pa	86	25. Was casa referred to medicat					26. Place	of Deeth	(Check only one	)			
yalc yalc dire	10	axaminar? 1 ☐ Yas 2∰ No	lospitat:	2 ER/Out	tpatient	3 DOA	Other: 4 Nu	ırsing Hor	na 5 Resider	nce 6 Oth	er (Specil	(y)	
VISION OT VITA Attending Physicien: ir deeth. ector: After this certific by the funeral director,		27. Manner of Death 1 Netural 5 Panding 2 Accident investigation	28a. Dete of Injury (Month, Day Ye	28b. T	ima of njury	28c. Ir V M 1	ijury at Vork? Yes 2		8d. Describe ho	w injury occur	red		
2 2 2 2 2	Certification:	3 Suicida 6 Could not be definition and	28a. Place of Injury building, atc. (S	At homa, far Specify)	rm, street	, lactory, office	×9	4	28f. Location (Str. City or Town,		er or Run	al Route Nui	mber,
Hospital     124 hours     Funeral C	edicai	29a. Certifier (Check only one) Certifying Physics (Check only one)	nar: On ma besis of axe any mannar stated	mination end	, death od Vor inves	curred at the tigation, in m	time, date an y opinion, daa	d place, e th occurre	nd dua to the can d at tha tima, da	use(s) and ma ta and plece,	anner as s and dua to	taled. o the cause	(s)
To the within 2 To the comple	Me	29b. Signeture and titla of contifier	h			29c. Lice	nse number		29	d. Data signe	d (Month,	Day, Year)	
F 3 F 0		(VII. 4.0) /	1000			N	0401	77	,	Novembe	ar 1	1000	
0		30 Name and district	1000	//	T		0100	12		MOVELLIDE	-L L,	1777	
(5)	/	30. Nama and addrass of person who					mac 36	1		4.0			
		Duane Taylor, M.D.			e Lai	ne, La	rgo, Ma	aryıa	ind 2074	43			
Sta Regist	ate	31. Data filed (Month, Day Year)	2. Registrer's	Signatura	1		-1						

104 05 490 Brown A Street

99-6735-031

Places Type or Print in Plack Indelible Ink. Accure All Copies Are Legible

9AMEND Doretha	ITEMS: #23 PART Elizabeth McDonald	I State of Maryland	Department of Health and N Certificate of Death	lental Hygiene	9 3	61	4
	1. Decedent's Name (First, Middle, La			2. Dete of Death		3. Time	

Physician	
/Medical	-
Examiner	

Doretha Elizabeth McDona 1 d

2. Dete of Death 3. Time of Deeth Day Month Veer NOVEMBER 9,1999 10:38A.M

4a Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death 4c. County of Death

**Funeral** Director

"natural", or items 23s or 28s-f show

Director

P

Completed

8

filed within 72 hours efter death with the Maryland

Hygiene.

. Peges 1 and 2 should be fill ment of Health end Mental Hants if Itam 27 is marked oth jury or other treumatic even

permit. Pege Department of Important: If any injury or phose.

**Physician** /Medical

Examiner

sicien and burial-transit

physicien s the burial

signed by the et d be detached fo

funeral

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Examiner

Physician/Medicai

À

Completed

8

Certification: To

Medical

21215-0020

Baitimore, Maryland

Box 68760,

P.O.

Records,

Division of Vitai or Attending Physician: WASHINGTON ADVENTIST HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 2 F

SILVER SPRING MONTGOMERY If Under 1 Yeer | If Under 24 Hrs.

577-54-3816 Usual Residence of Decedent

64

8. Dete of Birth (Month, Dey, 11-15- Birthplece (Stete or Foreign Country) TROY,

10a State 10b. County

MD PRINCE GEORGE'S 10c. City. Town or Location **ADELPHI** 

N.C. 10d. Inside City Limits

10e. Street and Number

11. Merital Status

10f. Zio Code

10a. Citizen of Whet Country?

U.S.A.

1804 METZEROTT ROAD, #401 12. Was Decedent Ever in U,S. Armed Forces?

20783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Hours

14. Race - American Indian, Black, White, etc. Specify: BLACK

1 Yes 2 □ No

1 Never Merried 2 Merried 3 E Widowed 4 □ Divorced

1 ☐ Yes 2 XNo 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 2 XNo Specify:

Days

Months

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12th

College (1-4or 5+)

UNEMPLOYED

N/A

17. Fether's Name (First, Middle, Last)

NASH

THOMAS

SADTE

LEDWELL

19a. Informant's Name/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

KALIFA - DAUGHTER 331 54th STREET, NE WASH.DC LORETTA

> 20b. Place of Disposition (Name of cemetery, cremetory or other place) T Dete

20c. Location - City or Town, State

20a. Method of Disposition
1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

FOREST HILLS MEM.GAR. 20-1999

CLINTON, MD

21. Signature of Funeral Service Licetise

TAYLOR AS FUNERAL HOME

1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one gause on each line. Approximete Intervel Between Onset end Death

18 Mother's Name /First Middle Maiden Surname

Immediate Cause (Final disease or condition resulting in death)

CARDIOMEGALY

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or es e consequence of)

23b. Did tobacco use contributa to the causa of death? 3 Probably 4 Unknown 1 Yes 2 No

24b. Were eutopsy findings available prior to

24a. Wes an eutopsy performed?

completion of cause of deeth?

1 Yes 2 No 26. Place of Deeth (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? TYNes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be 28a. Date of Injury (Month, Day Year)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2○ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Physician: To the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29c. License number O.C.M.E.

29d. Dete signed (Month, Dey, Year) NOVEMBER 10,1999

28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 sey seins KORou MM. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) NOV 1 5 1999

Registrer's Signeture

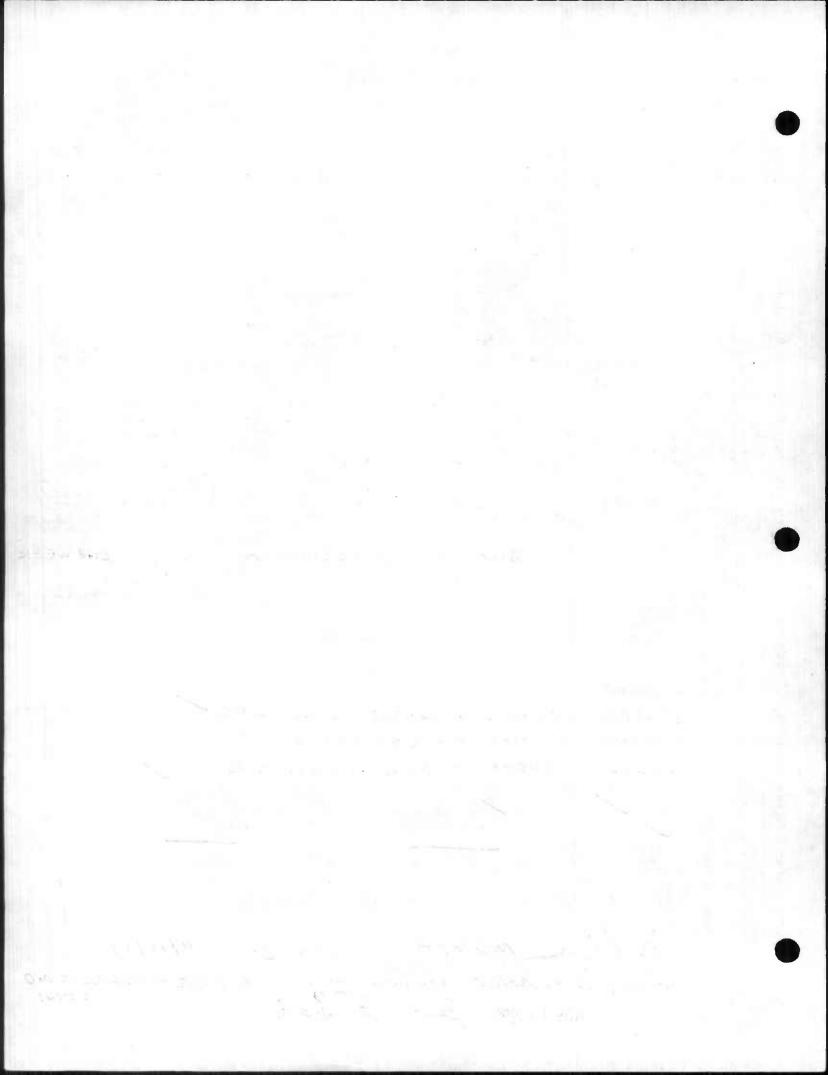
State Registrar

15 1399

General & Santa

State of Maryland / Department of Health and Mental Hygiene 9 36 14 3

	Certificate of	Death Reg. No.
	Decedent's Name (First, Middle, Last)	2. Dete of Death Month Day Year  3. Time of Death
Physician /Medical	STELLA MARIE MCFADDEN	Nov. 12, 1999 10:38 a
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Deeth
	ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS Anne Arundel
Funeral	Months Days	r If Under 24 Hrs. 8. Date of Birth 9. Birthplece (Stete or Fore
Director	266-32-7498 1□ M 2MF 76 Yrs. Months Days Usual Residence of Decedent	Sept. 1,1923 W. Virgin
A 11	10a. State 10b. County 10c. City, Town or Location	10d. fnside City Lim
or 28a-f at be notified Director	Maryland Anne Arundel Cape St. Clair	
	10e. Street and Number 460 Man O'War Court 2	1 4 0 1 USA
by b	11. Marital Status  1 □ Never Married 2 ☑ Merried  3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☑ No  11. Was Decedent of fit Yes, specify Cut fit Yes, Give Year or Detes:	Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.)  Specify:  14. Race - American Indien, Bleck, White, etc.  Specify: White
"natural".	15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done	upation 16b. Kind of Business/Industry adving most of working ad)
d duc	Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria	
d other vent.	17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
marked other matic event, I	Ralph Alberts	Grace
EE	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Stree	at and Number or Rural Route Number, City or Town, Stete, Zip Code)
T la	Cathy J. Cowman / Daughter 10600 Davis	Ave., C-1 Woodstock, MD 2116
Important: If I amy injury or adds.	21. Signature of Funeral Service Licensee 22. Name and Addr. Lincoln	. of Med. 11/12/99 Wash., DC  ess of Fecility & Lincoln Funeral Service costia Av., NE Wash., DC 2001
physician and a the buriel-transit authorities and a the buriel-transit authorities and a the buriel-transit authorities and a the buriel and	Immediate Cause (Finel disease or condition resulting in death)  a. BILATER AL PN E.  Due to (or es a consequence of):  b. Due to (or es a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	UMONIA
or use as	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):  d.	
igned by the a be detached i by Physic	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause gi	iven in Pert I. 23b. Did tobacco use contributa to the causa of de
de by	SEVERE CHRONIC OBSTRUCTIVE L	UNG DISEASE 11 Tos 2 No 3 Probably 4 Unkr
should should	CHRONIC LYMPHOCYTIC LEUKEN	24a. Wes en eutopsy performed?  24b. Were eutopsy finding eveilable prior to completion of cause
page 2	INSULIN DEPENDENT DIABETES	MELLITIUS 10 Yes 20 No 10 Yes 20 No
cartific irector	25. Was case referred to medical examiner?  1 Yes 2 No Hospitel: 1 Propatient 2 FR/Outpatient 3 DOA	26. Place of Deeth (Check only one)  ther: 4  Nursing Home 5 Residence 6 Other (Specify)
erthis eral d	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Inju	
to the		ork? ] Yes 2 □ No
To the Fueral Director: After this completely filled in by the funeral Medical Certification; 1	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Pletaly fills	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time of the companient of the basis of examination end/or investigation, in my and manner stated.	ime, date and place, end due to the cause(s) end menner es stated. opinion, death occurred et the time, date end place, end due to the cause(s)
Me Me		ise number 29d. Date signed (Month, Day, Year)
F 0	Mela MOMPH D3	8328 "/12/99
	20 Name and address of name who are that design of death (ben 00 a) (Te or 15 in)	
	MARY R CLANCE 180 AOMINA	L COCHRANE OR ANNAPOLIS M
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	21401
State	NOV 1 7 1990 herera 29	Source )



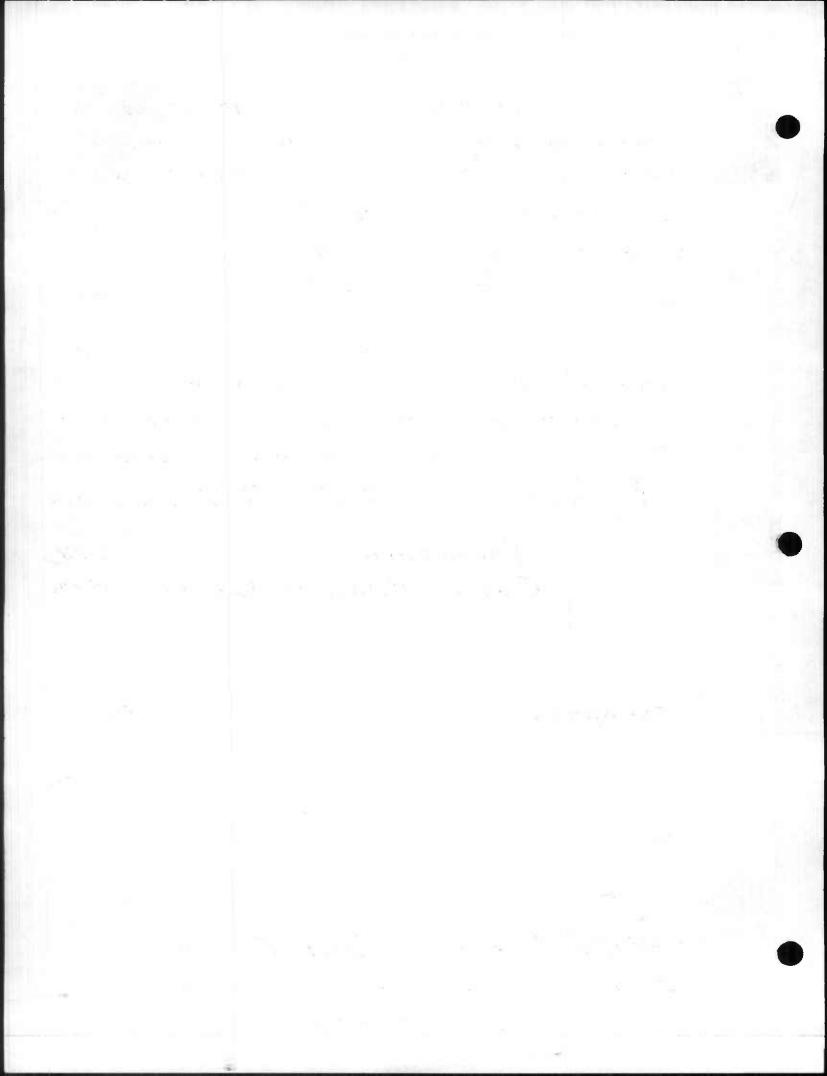
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** Walter Preston Mills, Jr. 10 6:30 AM 1999 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer)
9. Birthplace (Sten Country)
June 29, 1919 Maryland 5. Sociel Security Numbar 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Days Yrs 215-26-3925 Director 80 Usual Residence of Dacedent 10e Stete 10h County 10c. City, Town or Location 10d. insida City Limits 28a-f show Maryland Dorchester Cambridge 1 Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or Items 23s or 5102 Beaver Neck Village Road 21613 US Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 激发No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Raca - Amaricen Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White þ Specify: ¥₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygien Important; If them 27 is marked other th any injury or other framework Farmer Agriculture 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Preston Mills, Sr. Lena Horseman 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Walter P. Mills III 5104 Beaver Neck Village Rd Cambridge, MD 21613 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from State Dorchester Memorial Park 11/2/99 Cambridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) & Funeral Service Licensee 22. Name end Address of Facility
Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Perfi Entar tha disease, or complications thet caused tha daath. Do not entar tha moda of dying, such as cerdiac or respiretory errest, shock, or heart feliure. List only one cause on each line. **Physician** /Medical fmmediete Ceuse (Final diseesa or condition resulting in death) [ NEUMONIA Examiner Examiner To the Mospital or Attending Physician: The law requires that the death certificate be assocuted within 42 hours attendeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the internal director, page 2 should be deteched for use as the burial-transit completaly filled in by the internal director, page 2 should be deteched for use as the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown Ostroporosis 1 ☐ Yes 2 ☐ No Division of Vital Records, þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 2 No 1 ☐ Yes 25 No 1 Yes Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 28 No Other: 

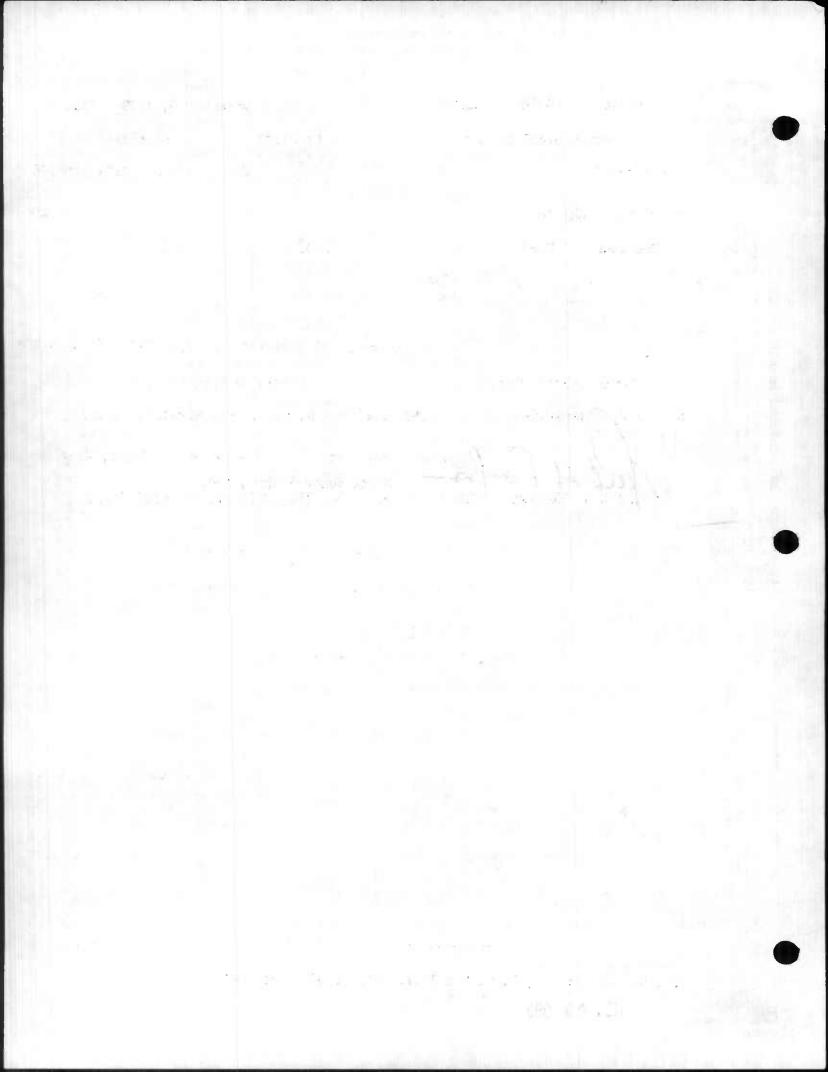
Surrsing Home 5 ☐ Residenca 6 ☐ Othar (Specify) Medicai Certification: To 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. fnjury et Work? Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physicisn: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael F. Fadden, MD 302 Collins Avenue Hurlock, Maryland 21643 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 02 1999



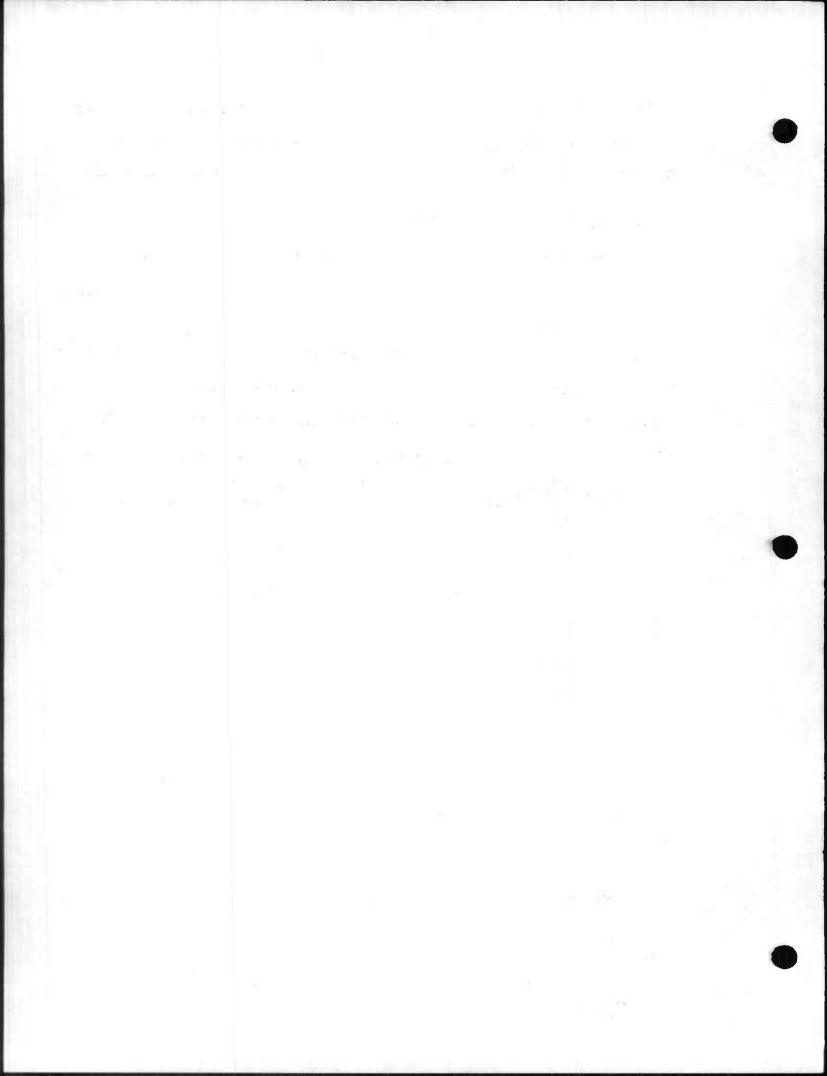
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 36 145

				Certificate of	or Death		Reg. No.		
Physician	1. Decedent's Nema (First, Middle CHADI EC		GERS			2. Deta of Month	Dev	3. Tima of Deeth 7:10 AM	
/Medical	CHARLES  4e Fecility Neme (If not institution				4b. City, To	NOVEMI wn, or Location of Da	per 4, 19		
Examiner		edical Cente			La P1		Char		
Funeral Director	5. Sociel Security Number 217-42-0008	6. Sax 1 M 2 □ F	ga (In yrs. last birti	hday) If Undar 1 Y rs. Months Do	ear If Under eys Hours	24 Hrs. 8. Date of (Month, July)	Birth (Pay, Year) 31,1942	9. Birthplace (State or Foreign Country) Washington, DC	
	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	er Location				10d. Inside City Limits	
natural, or items 23a or 28a-f show died Evanime must be notified at sted by Funeral Director		arles		aldorf			1 □ Ye		
23a or 2 salbene al Dire	10e. Street end Number 2980 Double F	Road		10f. Zip Cod	20603		U.S.A.		
al', or items 23a or 28a-f abow Examinet must be notified at by Funeral Director	11. Maritel Status  1 Never Married 2 Marriad 3 Widowed 4 Divorced	If Yes Give	1964-	13. Was Decedent If Yes, specify (		igin? (Specify Yes or n, Puerto Rican, etc.)	No- 14. Rad Ble Specif	ce - American Indien, ck, White, etc.	
natural'. edical Exe	15. Deceden (Specify only highes	t's Education st grade completed)	16a.	Decedent's Usual O (Give kind of work d life. DO NOT use re	ccupetion one during mos	at of working	16b. Kind of B	usiness/Industry	
then the	Elementary/Secondary (0-12)	College (1-4or		istant Ch			0perati	ons/Maintenance	
marked other matic event, t	17. Fathar's Nama (First, Middla, Thomas Ste	Lası) Ewart Rogers				ar's Neme (First, Midd rlotte Rut			
T 49 T	19e. Informent's Name/Relations Brenda F Roger	hip (Type, Print) 's/Wife				er or Rural Routa Nui ,Waldorf,			
r other tr	20s. Method of Disposition	3 DRamandon State		Disposition (Nema o	of plece)	Dete	20c. Location	- City or Town, State	
tant: I	4 Donation 5 Donner (S	pegify)	Hunti	Cremator	-	11-08-1		dorf, Maryland	
Department Important: I	MARK G	BROHAWN MO	100E2			Home, Inc		0156	
	23a. Pert1. Enter the disease, or shock, or heert failure. List	complications that cause	00053 ed the death. Do n			Waldorf, cardiac or respiretor		Approximate Interval Between	
e etanding physician end ad for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in deeth) Last	c. Acute	As ci (	ニつ		y an yndr	ene		
d by the ettandetached for us	Pert II. Other significent condition	ons contributing to death	but not resulting in	the underlying ceus	e given In Pert			ontribute to the cause of death?	
igned by be deta						'	☐ Yes 2☐ No	3 Probably 4 Unknow	
should should							es en eutopsy erformed?	24b. Were autopsy findings eveitable prior to complation of causa of deeth?	
pega 2						1	Yes 2000	1 ☐ Yes 2 ☐ No	
certificate rector, per	25. Wes case referred to medica examiner?				-	e of Deeth (Check on	ly one)		
T T	1 ☐ Yes 2 No	Hospital: 1 Thpa				ursing Home 5 R	esidence 6 🗆 Ot		
fler no	1 Maturel 5 □ Pendir 2 □ Accident Investi		jury 28b. T ay Year) Ir	njury M	Injury et Work? 1 Yes 2		oe now injury occu	1160	
rs eftar death. al Director: After ted in by tha funera Certification:	3 Suicide 6 Could determ	ined 286. Piece of I	njury - At home, fe etc. (Specify)	rm, street, factory, of	fice		n (Street end Num Town, State)	ber or Rurel Route Number,	
within 24 hours eftar death.  To the Funeral Director: A completely filled in by tha te	29a. Certifiar Check only one) Certifylr	g Physician: To the bes	of exeminetion end	death occurred et the	ne time, date ei my opinion, de	nd plece, end due to tath occurred at the tin	he ceuse(s) end n	renner es steted. , and dua to the ceuse(s)	
omple omple	29b. Signature end title of certifie	end menner s	stateu.	29c. Li	cense number		29d. Date sign	ed (Month, Day, Year)	
> = 0	) Lake	ed 9	Auto	wro	D31	675	4 M	0299	
	30. Name end eddress of person			Type, Print)					
	Dr. Waheed Ak			7, White	Plains,	MD 20695			
		20 Doots	trer's Signature						



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	ITEM #26	Sta AS PER DOCTOR 11/9/99	te of Marylan  CCHD FCB		nt of Healt <i>te of Dea</i>			iene 9 (	9 36	146
	Physician	1. Decedent's Neme (First, Middle, Last)					2. Dete of Deel Month	h Dey	Yeer 3.	Tima of Deeth
	/Medical	JOAN CROMAR PIPES			4h Cin	y, Town, or Loc	OVEMBER	7, 199		:30 AM
	Examiner	4a Fecility Name (If not Institution, give street e 8425 Welcome Woods				Welcome		4c. County		
	Funeral Director	5. Social Sacurity Number 6. Sex 1 □ M 2%	7. Aga (In yrs. I	Vrs. If Und		tre Min	8. Date of Birth (Month, Dey July 14	, 1932	9. Birthplece Country) Washin	(State or Foreign gton DC
	wo	Usual Residenca of Decedent  10e. State 10b. County	10c. City	y, Town or Location					10d. I	nside City Limits
	Meny France	Maryland Charles	V	Welcome					1	☐ Yes Ma ☐ No
	or 28s	10e. Street and Number			ip Code		1	0g. Citizen of W		
	s 23a	8425 Welcome Woods Pl			20693			US		don
020	72 hours after deeth with the Meryland natural; or items 23a or 28a-f show yield Exercises must be notified at steed by Funeral Director	1 Never Married 2 Married 1 If You	s Decedent Ever in U, led Forcas? Yas 2 DNo es, Give Ir or Datas:		edant of Hispenic ecify Cuban, Ma:		ciry Yes or No- lican, etc.)		e - Amarican Ir k, Whita, etc. . Wh	ite
5-0	natural,	15. Decedent's Education (Specify only highast grede comp.	leted)	16e. Decedent's Us (Give kind of v	uel Occupetion rork done during use retired)	most of working	a	16b. Kind of Bu		
Maryland 21215-0020			ege (1-4or 5+)	School Se	cretary				School School	's System
land	d out	17. Fether's Neme (First, Middle, Last) Theodore Robb Cromar				lother's Name		Meiden Sumem	e)	
lary	0 0 3	19a. Informent's Neme/Reletionship (Type, Prin		19b. Meiling Addre	ss (Street end N	umber or Rurel	Route Number			(e)
	end 2 m 27 li	Timothy M. Eagan-Son		30080 Bo		, Mechai				04-4-
Baltimore,	permit. Pages 1 end 2 Department of Health of Important: If Item 27 is any Injury or other tra	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Remova	from State	taca of Disposition (Nemetery, cremetery or ryland Vet	other place)	Com 11.		20c. Location - Chelten		
Him	Department Department Important: Iny Injury	4 Donetion 5 Other (Specify)	l'ia i	•				Che i cen	main, m	
Ba	med del0 del0 sqmi	a Devettur	10.0164		Funeral Box 156			20604-	0156	
		23a. Pert1. Enter the disease, or complications shock, or heart failure. List only one caus							App	proximete prval Between
1	Physician /Medical									set end Deeth
	Examiner	Immediata Causa (Final disease or condition resulting in death)	IETASTA			CARC	-1 WOM	H	ري	x pired
			SEVERE	r es e consequence o	NUTRI	NOIT				-30 AM
	executed in end iel-transit	D		r es a consequence o		11010	*			on
8760,	be executed sician and buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury c.							11	17/99
687	the the	that Initiated events resulting in deeth) Lest	Dua to (or	r as a consequenca of	):					
Box	eath certific ettending p for use es	d								
	death he etter hed for u	Part II. Other significant conditions contributing	g to death but not resu	ulting in the underlying	cause given in f	Pert I.	23b. Dld to	obacco use cor	ntributa to the	cause of death?
P.0	requires that the death certifit been signed by the ettending probes should be deteched for use es						1 🗆 Y	08 2X No	3 Probabl	y 4 Unknown
Records,	een sign hould be						24a. Wes		24b. Were e	utopsy findings
000	The lew require page 2 should Completed						perfor	med?		ole prior to ation of cause h?
	The law sate has page 2						1□ Y	es 2 No	1 □ Ye	s 2 No
Vital	certificate rector, pag	25. Wes case referred to medical examiner?				Plece of Death	(Check only or	16)		
of	Physician: this certific ral director, To Be	1 ☐ Yes 2 No Hospital  27. Menner of Deeth 28a.	1 inpatient 200	€R/Outpatient 3□ 1 28b. Time of				ence 6 Oth		
o	Attending In deeth.  Sctor: After by the fune	1 Network 5 Pending 2 Accident investigation	Dete of Injury (Month, Dey Year)	Injury	28c. Injury et Work? 1 ☐ Yes		og. Describe in	ow injury occur	60	
Division	Patric T	2 Cuiside 6 Could not be	Pleca of Injury - At he building, etc. (Specify	ome, ferm, street, fect	ory, offica	2	8f. Location (S City or Tow	treet end Numb n, Stete)	er or Rural Ro	ute Number,
	n 24 hours on 24 hours on Funeral pletely filled	29a. Certifier (Check only one) 1 Certifying Phyalclan: 2 Medical Examiner: On en	To the best of my know the besis of examined manner stated.	wledge, deeth occurre tion end/or investigation	d et the time, de on, in my opinion	te end piece, e , death occurre	nd due to the o	euse(s) end me ate end pleca,	enner as steted end due to the	1. cause(s)
	within 2 To the comple	29b. Signeture end title of certifier		2	9c. License num	ber	- 1	29d. Date signe	d (Month, Dey	Year)
	P > P 0	Jalish Juna	mi. M	· d.	0352	95		1118	199	
		30. Nema end addrass of person who complete	d cause of deeth (Itam	23e) (Type, Print)		0 - 0 1		1006	03	
		10 ST. PATRICKS  31. Dete filed (Month Pay, Year)	32. Registrer's Signa	1236) (Type, Frint) いてこ208	, WH	LIJORA	, ,	200	, O ,	4
	State	31. Dete filed (Month Day, Year) NOV () 9 1999	SZ. Hagistra s Signa		6.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Benjamin J. Rious Sr. NOVEMBER 1, 1999 9:50 am 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY if Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 5. Sociei Security Number 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) Months Yrs 240-09-9081 78 JULY 9, 1921 SOUTH CAROLINA Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No WASHINGTON, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5113 13th ST N.W. 20011 UNITED STATES OF AMERICA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) entery/Secondery (0-12) College (1-4or 5+) 8th grade MAINTENANCE SUPERVISOR PRIVATE INDUSTRY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN RIOUS ETTA (UNKNOWN) 19e. Informent's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ERMA RIOUS / WIFE 5113 13th ST NW WASHINGTON DC 20011 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State cometery, cremetory or other place) 11/6/99
MARYLAND NATIONAL CEMETERY 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete BELTSVILLE, MARYALND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME ure of Funeral Service Licensee 716 KENNEDY ST NW WDC 20011 301 23a. part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) e. CARDIOPHLMONARY ARREST Due to (or es a consequence of) 5 days ASPIRATION PNEUMONIA Due to (or es a consequence of) BOWEL OSTRUCTION 2 days Due to (or es a consequence of) 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 TYes 2 No

**Physician** /Medical Examiner

physician and the burial-transit

for use es 80 esn

ed by the a

signed b

Box 68760,

P.O.

Records,

Division of Vital

thet the daath certificate be

requiras should

The lew hes e 2 page cartificata

Hospital or Attanding Physician: 24 hours efter daath. Funeral Director: After this cartifice stely filled in by the funeral director;

24 hours

10 m 200

10

Physician/Medical Examiner

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Completed

Be

Certification: To

edicai

**Physician** 

/Medical

**Examiner** 

Director

Funeral

à

Completed

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21. Signe

10a. Stete

**Funeral** 

Director

ahow notified at

à

238

the Medical Examiner must be

"natural", or Items

other

permit. Pages 1 and 2 should be fish Department of Health and Mental: Hy Important: If them 27 is marked othy any injury or other traumetic event

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

OBSTRUCTIVE UROPATHY

CVA with APHASIA

25. Wes case referred to medical exeminer? ▼ 1 ☐ Yes 2 ☐ No

27. Mapner of Deeth 5 Pending investigation 1 Naturel 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Dete of Injury (Month, Day Year) 28b. Time of Injury

Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. injury et Work?

D52251

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1X Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) 29b. Signature and 12 certified 29c. License number 29d. Date signed (Month, Dev. Year)

un 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

ALAN R. Segal 1299 Kamberton

NOVEMBER 2, 1999 Dr. Silver Spring MD 20902

ALAN R. Segal
31. Date filed (Month, Day, Year) NUV 0 4 1994

32. Registrer's Signeture

State Registrar

## Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O

	1. Decedent's Neme (First, Middle,	Last)				2. Dete of De		3. Time of Death
hysician /Medical			OYSTER		# 02 T	Novem		1999 06:13 PM.
xaminer	4e Fecility Neme (If not institution, Prince G	eorge's Hospita	al Center		Cheve:	r Location of Deet rly	1	nce George's
neral ector	5. Social Security Number 217–55–3763  Usual Residence of Decedent	Sex 7. Age (In yrs	s. last birthday) If Un Yrs. Mont	hs Deys	If Under 24 H		1999	9. Birthplece (State or Foreign Country) CHEVERLY, MI
Director	10a. State 10b. County		City, Town or Location  IVERDALE					10d. Inside City Limits 1 1 Yes 2 □ No
ral Director	10e. Street and Number 6831-A RIVER	DATE PD #2		Zip Code	737		10g. Citizen of	Whet Country?
ar, or hems Examiner or by Fune	11. Meritel Stetus  1 Never Merried 2 Marrie  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?	U,S. 13. Was De			(Specify Yes or No erto Rican, etc.)	0- 14. Rad Bla	ce - American Indien, ck, White, etc.
Completed b	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education	16a. Decedent's U (Give kind of life. DO NO	work done	during most of w	rorking	16b. Kind of B	usiness/Industry
Con	0 17. Fether's Neme (First, Middle, La			N/A	40 Mathada N	eme (First, Middle	Moiden Sumer	N/A
To Be	ORLANDO	ROYS	TER		LASHA		, maider Sumer	MAYHEW
or traumal	19e. Informent's Neme/Relationship LASHANTRA MAY							State, Zip Code) 20706 MARYLAND
any injury or other	20e. Method ol Disposition  1 X Buriel 2 Cremetion 3 4 Donetion 5 Other (Spe	☐Removal from State	Place of Disposition (cemetery, cremetory) T. OLIVE	or other pie	∞) METERY	ትሄ – 17–199		City or Town, State  INGTON, DC
ician dical niner	Pen1. Enter the disease, or construction in the shock, or heart feiture. List or immediate Ceuse (Final disease or condition resulting in death)	PN		node of dyi				ASH. DC 20001  Approximate Interval Between Onset end Death
I for use as the buriel-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	c	(or es a consequence					
Physi	Part II. Other significant conditions	contributing to death but not re	ontributing to death but not resulting in the underlying cause given in Pert I.					ontribute to the cause of death?  3 Probably 4 Unknown
should be ted		H <sub>2</sub>				24a. Wes	s en eutopsy ormed?	24b. Were eutopsy lindings eveilable prior to completion of cause of death?
page 2						128	yes 2□No	12 No 2□ No
Be Be	25. Wes case referred to medical exeminer?	Hospital:		Oil	26. Place of D	eeth (Check only	one)	
T.	1 X Yes 2 No  27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigal	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 LI Nursing	Home 5 Res 28d. Describe	how injury occur	
Medical Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury - At building, etc. (Spec	home, ferm, street, lac ≆fy)	tory, office			(Street and Numi own, State)	ber or Rurel Route Number,
= -	20a Cartifice 10 Cartifica	Physician: To the best of my kn	nowledge death cour	ad at the ti	me date and ola	ce and due to the	cause(s) and m	
mplataly filled		aminer: On the basis of examin and manner stated.						

State Registrar

31. Dete filed (Month, Day, Year)
NOV 1 5 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

November 12, 1999

666. ST. 1838 the franch

## nt in Black Indelible ink. Assure All Copies Are Legible.

CU		riease	Type of Print in Black ind
Harlan Delno	Snow		State of Maryland / Depar
AMEND TTE	EMS: #23	PART	T 27 PER MED G77

tment of Health and Mental Hygiene Certificate of Death

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1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Delno Snow Harlan November 04 1999 05:46 AM. 4b. City, Town, or Location of Death eet and number) 4c. County of Death 410 Ridge Road Rising Sun Cecil If Under 1 Year If Under 24 Hrs. Data of Birth (Month, Day, Jan. 3 Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Days Hours Months 4 2□ F Jan. 10c. City, Town or Location 10d. toside City Limits Rising Sun 1 ☐ Yas 2 No 10f. Zip Code 10g. Citizen of What Country? 21911 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 1 ☐ Yas 2 No tt Yas, Giva Yaar or Detas: 1 Yas 2 □ No Specify: Specify: white 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry lon ompleted) Collega (1-4or 5+) extrusion operator manufacturing 18. Mothar's Nama (First, Middle, Maiden Sumama) Barbara Johnson , Pnint) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 410 Ridge Road, Rising Sun, MD 21911 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Steta noval from Stata Oxford Cemetery 11/9/99 Oxford, PA 22. Name and Address of Facility Collins Funeral Home, 86 Pine St., Oxford, PA Approximata Intarvat Between Onset and Death tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, CAPDIOMEGALY Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Dunknown

1 ☐ Yes 2 ☐ No

O.C.M.E.

25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatiant XXYas 2□ No 2 ER/Outpatient 3 DOA

24b. Ware autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death?

November 4, 1999

1 Yes 2 No 1 No 2 No

Other: 4 ☐ Nursing Homa 5 🖾 Rasidence 6 ☐ Other (Specify) 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 , Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant

6 Could not be datarminad 3 Suicida 28a. Place of tnjury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Phystclan: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signeture and sittle of certifie

29a. Certifier

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

THEMORE MKING 31. Data tited (Month, Day, Year) NOV 0 8 1999

32. Registrar's Signatura

Hospital or Attending Physicien: The law requires that the deeth certificate be execute

Division of Vital Records, P.O. Box 68760,

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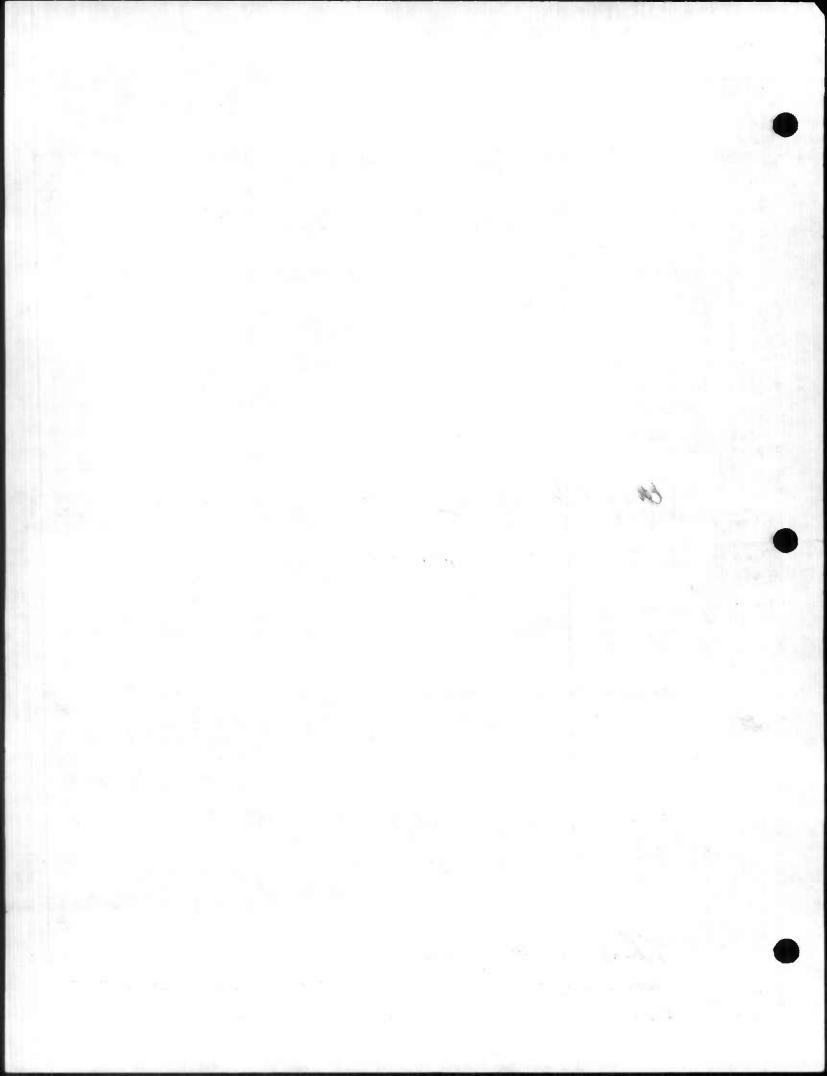
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State of Maryland / Department of Health and Mental Hygiene 9 9 3 6 | 5 0

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JV 0 5 1938 James & James J.

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** NOVEMBER 02, 1999 1230 Matrena Taidakova /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** #518 PARK PRINCE GEORGIA 4800 BERWYN HOUSE READ COLLEGE 8. Dete of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2X F Months Deys Hours Min. Yrs. 3, N/A 84 Russia Director Nov. Usuel Residence of Decedent with the Marylenc 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r 28a-f show 1 Nes 2 No Maryland Prince George's College Park Direct 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number Pages 1 end 2 should be filed within 72 hours after death with nent of Health end Mentei Hygiene.

ant: if Item 27 is marked other than "natural", or Items 23a or ury or other traumatic event, I've Madical Examinat maint be in 4800 Berwyn House Road, #518 20740 Russia Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Factory Worker Government 18. Mother's Neme (First, Middle, Maidan Surnama) 17. Fether's Neme (First, Middle, Last) Be Arkhip F. Kharin Irina K. Gabova 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Nikolai N. Gorkavyi - Son-In-Law 4800 Berwyn House Rd., #518, College Park, MD 20740 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Depertment of Important: If any Injury or pace. Maryland National Cemetery 11/05/99 4 ☐ Donetion 5 ☐ Other (Specify) Laurel, Maryland 22. Name end Address of Fecility
Gasch's Funeral Home, P.A. 21. Signeture of Funeral Servica Licensee 4739 Baltimore Avenue, Hyattsville, MD en 20781 asch-Noe 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert failura. List only ona causa on aach lina. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition rasulting in death) /Medical ARTEROSCIEROTIC CARDIOVASCILLAR Examiner Dua to (or es e consaquenca of): Examiner the death certificate be executed physician and s the burief-trens Saquentially list conditions, if eny, leading to Immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): 98 esn signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to Completed 24a. Was en eutopsy performed? should peen completion of cause of death? pege 2 : hes 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funerel director. 25. Wes case referred to medical examinar? 26. Pleca of Deeth (Check only one) Othar: 4 Nursing Home 5 Residenca 6 Other (Spacify) 1 Yes 2□ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28d. Describe how injury occurred 28b. Tima of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? After 1 Natural 2 Accident 5 Pending 1 ☐ Yas 2 ☐ No 24 hours efter deeth. investigation 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicida edicai 29a. Certifian 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the ceuse(s) end menner as steted. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or Investigetion, in my opinion, deeth occurred et tha tima, dete end placa, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title use of daeth (Item 23a) (Type, Print) 3601 HOSP MARIO F. GOLLE DRIVE CHEVERLY MARYLANY) 31. Dete filad (Month, Day, Year) 32, Registrar's Signature State NOV 0 5 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Nov. **Physician** 1999 5:07PM Leo Francis Townsend, Sr. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Dey, Year) Dec. 6, 1930 If Under 24 Hrs. 7. Aga (In yrs. lest birthdey) If Undar 1 Yaar 9. Birthpleca (Stete or Foreign **Funeral** Min. Deys 1∏M 2□F Months Hours Wash., D.C. 579-38-0192 68 Yrs. Director Usual Residence of Decedent the Meryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r 28a-f show 10a. Stete 1 √Yes 2 No Prince George's Maryland Forestville Directo 10g. Citizen of Whet Country? 10f. Zip Coda 10e. Street end Number Pages 1 end 2 should be filed within 72 hours efter deeth with Innent of Health and Mentel Hygiane.
Int: If Item 27 Is merked other than "natural", or items 23s or inty or other traumetic event, the Madical Examinational Event 2541 Oak Glen Way 20747 United States Funeral 12. Was Decedant Ever in U,S.
Argued Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - Amarlcen Indian Black, White, etc. 1 Never Married 2 Married Black 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Yaar or Dates: Completed 16a. Dacedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Mechanic Government 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Silas Townsend Dorothy Moore 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2541 Oak Glen Way, Forestville, MD Dorothy Butler - Daughter 20747 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Page Depertment of Important: If any Injury or Lee's Crematory 11-10-99 Clinton, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility ure of Eunerel Service Licensae Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 1 ewas nter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiretory errest, in heart failure. List only one cause on each line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immediate Ceuse (Finel CONGESTIVE diseese or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner CARDIOMYO LATED requires that the death certificate be executed physician end the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Lest Due to (or es a conseguança of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequenca of) 80 usa for signed by the a d be detached f Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION à 24b. Wera eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy been page 2 certificate hes 1 Yas 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: director Be 25. Was cese referred to medical 26. Pleca of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 2 2 ER/Outpatient 3 DOA this tha funeral 27. Manner of Death 28e. Deta of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending 1 Naturel after death. 1 Yes 2 No Investigation 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 D Homicide To the Hospital within 24 hours a To the Funeral D completaly filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29e. Certifier edicai 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signeture end title of continue alle MD 3885 30. Nema and address of persopr)who completed cause of deeth (Item 23e) (Type, Print) CUNTON 307 7501 SURRATTS (COAD VENKAT. S. KAMAWAN 31. Dete filed (Month, Day, Year) NOV 0 5 1999 32 Registrer's Signatura State Registrar

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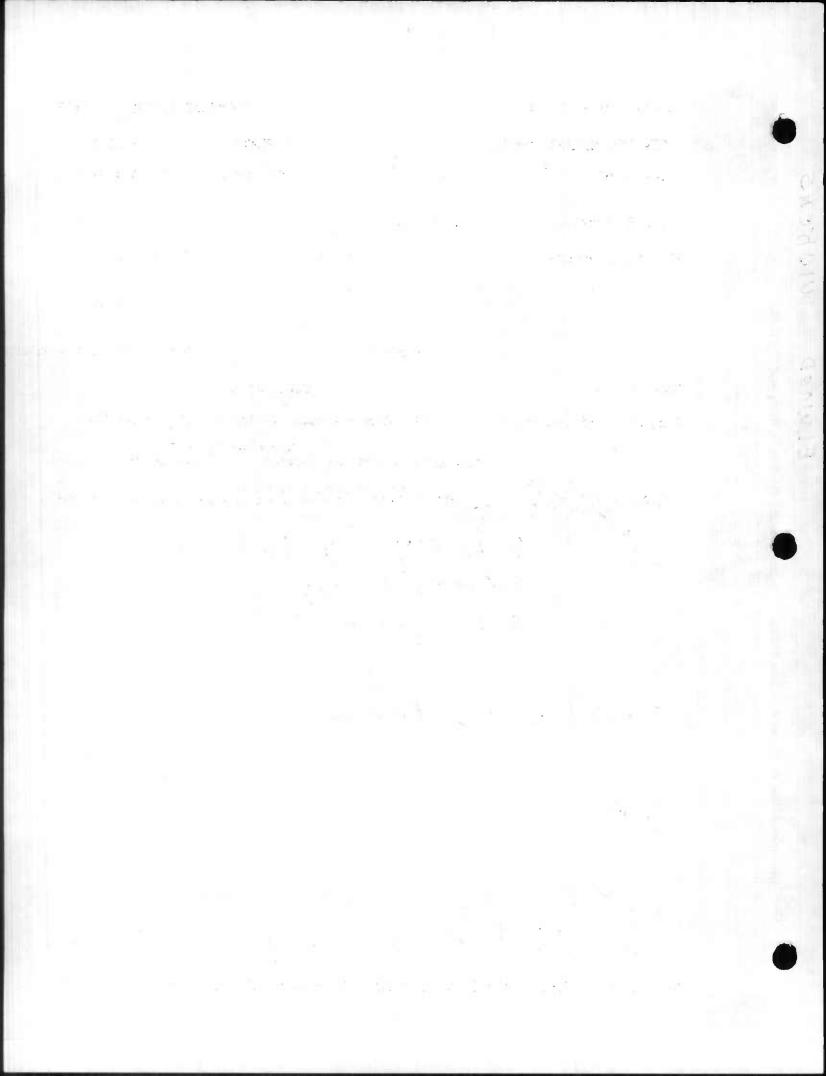
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WATSON 13-1999 MIRIAM 6=46 AM NOV /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 9E HUSPITAL FALLSTON ALLSTON HARFORD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 10 M 20 F 219-03-2221 89 Sept. Director 15, 1910 Maryland Usual Residenca of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f Maryland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Rems 23a 611 Biddle Street 21915 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 r than "natural", or the Medical Exams 1 Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Bank Clerk Retail Banking 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fin Department of Health and Mantal Hy Important: If Nem 27 is marked other any Injury or other traumatic event Be Clarence Harrington 2 May Bungard 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sandra F. Tracy/Daughter 2506 Rocks Rd. Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from State Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-5-99 Chesapeake City, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 318 George St. Chesapeake City. MD 21915 Part Epil the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ASCVD disease or condition resulting in death) Examiner Examiner sicien and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760, Completed by Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Division of Vital Records. 24a. Was en autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturat 5 Pending efter deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number NOU1199 1) ME 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) FULFORD AVE BELAIR MO 21014 NABHU (10 MN 218 31. Date filed (Month, Dey, Year) 32. Registrar's Signature OV 03 1999 Registrar Darks

# ELWOOD WICKENS

	State of	Maryland		irtment o tificate d		and Mental F	tygiene Reg. No.	99	36	55
1. Decedent's Neme (First, Mic	idle, Last)					2. Dete of Month		Yee		e of Death
Elwood Larry	Wickens					NOVEM	BER 4,	1999	-	55 AM
e Fecility Neme (If not institut		ber)			4b. City, T	own, or Location of D	eth 4c.	County of De	eeth	
CIVISTA MED  5. Social Security Number		7. Age (In yrs. las	t hirthday)	If Under 1 Ye		LAPLATA or 24 Hrs. 8, Dete of	Birth Dey, Year)		RLES Birthplece (Str	ete or Foreign
224–30–8153	1∭ M 2□ F	68	Yrs.	Months Da		Min. (Month, September	Dey, Year) 29, 19	31 Vi	Country) rginia	
Jsuel Residence of Decedent	***		Town or Lo	ontion						le City Limits
										Yes 2 No
faryland   Charl	_es	Indi	an He	aci 10f, Zip Cod	le		10g. Citiz	en of Whet	Country?	
22 Potomac Ave	nue			206				ed St		
11. Meritel Status	12. Wes Deced	dent Ever in U,S.	13. V			origin? (Specify Yes or an, Puerto Rican, etc.)		4. Race - Al	merican Indie	n,
1 Never Merried 2 M 3 Widowed 4 Divorce	If Yes Give	2 📉 No ∋		r ves, specily C				Black, W Specify: W	hite	
15. Decad	ent's Education		16e. Deced	lent's Usuel Ockind of work do	cupetion	net of working	16b. Kin	nd of Busine		
(Specify only high Elementary/Secondery (0-12	hest grade completed) College (1-	4or 5+)	life. L	OO NOT use re	tired)	or working				
17 Estheric None (First Later	3		Engi	neer	46.84	her's Neme (First, Mid			ates G	overnme
17. Fether's Neme (First, Middle	G, L85()					ie Jones	ura, maidan i	Jumente)		
Emery Wickens  19e. Informent's Neme/Relation	nship (Type, Print)		19b. Mailin	g Address (St		ber or Rurel Route Nu	mber, City or	Town, State	e, Zip Code)	
Jacqueline Wic						Indian He				
20a. Method of Disposition		20b. Ple		sition (Neme o	f	Dete	20c. Loc	-	or Town, Stel	te
1 ☐ Buriel 2 【 Cremetio 4 ☐ Donetion 5 ☐ Other		Metropo			11	Jovember 5, vice	1999 Alexa	ndria	, Virg	inia
Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest  Part II. Other significant conditions.	c. Alm	Due to (or e	ne consequence of the consequenc	uence of):  uence of):	rfis.		Old tobacco	1		use of death?
Intest:	tial La	ing	Dis	easl			☐ Yes 2	YNo 3□	Probably	4 Unknown
		0				24e. V	Ves en eutop erformed?	sy 24	lb. Were euto eveilebte p completior of deeth?	rior to
						1	☐ Yes 1	No	1 🗆 Yes	2 No
25. Wes case referred to medi	cel				26. Ple	ce of Death (Check of				
examiner? 1 Yes 2 No	Hospital: 1 ☐ In	patient 2 E	R/Outpatien	t 3 DOA	Other:	Nursing Home 5□ F		Other (S	Specify)	
27. Menyler of Deeth  1 Natural 5 Pen- 2 Accident inve	28e. Dete of (Month)	f tnjury n, Dey Year)	8b. Time of Injury		Injury et Work? 1 ☐ Yes 2 ☐		be how injury	occurred		
3 Suicide 6 Cou 4 Homicide dete	td not be mined 28e. Place of building	of Injury - At hom g, etc. (Specify)	e, farm, str	eet, fectory, off	ice		on (Street end Town, State)		r Rural Route	Number,
29a. Certifier Certific (Check only one) Certific	ying Physician: To the base at Examiner: On the base and menner	sis of exeminetio	edge, deeth n end/or inv	occurred et th	e time, dete e ny opinion, de	end plece, end due to eeth occurred et the ti	the cause(s) ne, date end	end menner place, end	r es steted. due to the cau	use(s)
29b. Signeture end title of certi	fiel Cho	1	Mib	29c. Lic	ense number	4	29d. Date	e signed (Me	onth, Day, Ye	99
30. Name end eddress of person SONG C. CHON 31. Dete filed (Month, Day, Yea NOV 0	M.D. CENNA		L CEN		POST	OFFICE RO	AD WA	LDORF	MD.	20602

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



,		
	Certificate	of Death

3. Time of Deeth

6:00pm

1 No Yes 2 No

Approximete Interval Between Onset end Death

with the Maryland 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinal must be notified at death 2 should be filed within 72 hours after of end Mental Hygiene. Is marked other than "natural", or iter Baltimore, Maryland 21215-0020

> **Physician** /Medical Examiner

physician and the bunal-transit law requires that the death certificate be executed 88 for use as signed by the a should should page 2 s The T certificate or Attending Physician: director, this After this funeral death. within 24 hours after death To the Funeral Director: / completely filled in by the I Hospital To the 1 Within 2 To the 1

Be

P

Certification:

edical

Box 68760

o.

Records.

Division of Vital

2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 30,1999 DOROTHY **FORTUNA** PARKER-WILLIAMS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner MILLENNIUM HEALTH & 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F 42 Yrs. 579-78-7970 Director TEXAS Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo VA FAIRFAX RESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 2180 CARTWRIGHT PLACE 20194 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced by Completed 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondery (0-12) 12th College (1-4gr 5+) COMPUTER GRAPHICS TECH remit. Peges 1 end 2 should be file. Peges 1 end 2 should be file. Important: If tem 27 is mere any injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) HENRY **EDWARD** PARKER, SR. HENRIETTA VIVIAN FORTUNE 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JELANDA P. WINSTON -DAUGHTER 1603 BECONTREE LANE, #2B RESTON, VA 20190 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 11-1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) RIVERDALE PARK CREM. 5-99 RIVERDALE, MD 21. Signature of Furlary Spring License TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC Part. Enter the disease, or complete ons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only obe cause on each line. Immediate Ceuse (Final END STAGE AUTO IMMUNE DEFIENCY DISORDER disease or condition resulting in deeth) Due to (or es e consequence of): Examiner CACHEXIA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco uea contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown by 24e. Was en eutopsy Completed

24b. Were eutopsy findings evailable prior to completion of cause of death? 1 Yes X No 1□ Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Yes 2 No Other: Wursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28h. Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated.

(Check only one) 29b. Signeture end 1 per certifier 29c. License number 29d. Date signed (Month, Dey, Year)

D0024100

November 4,1999

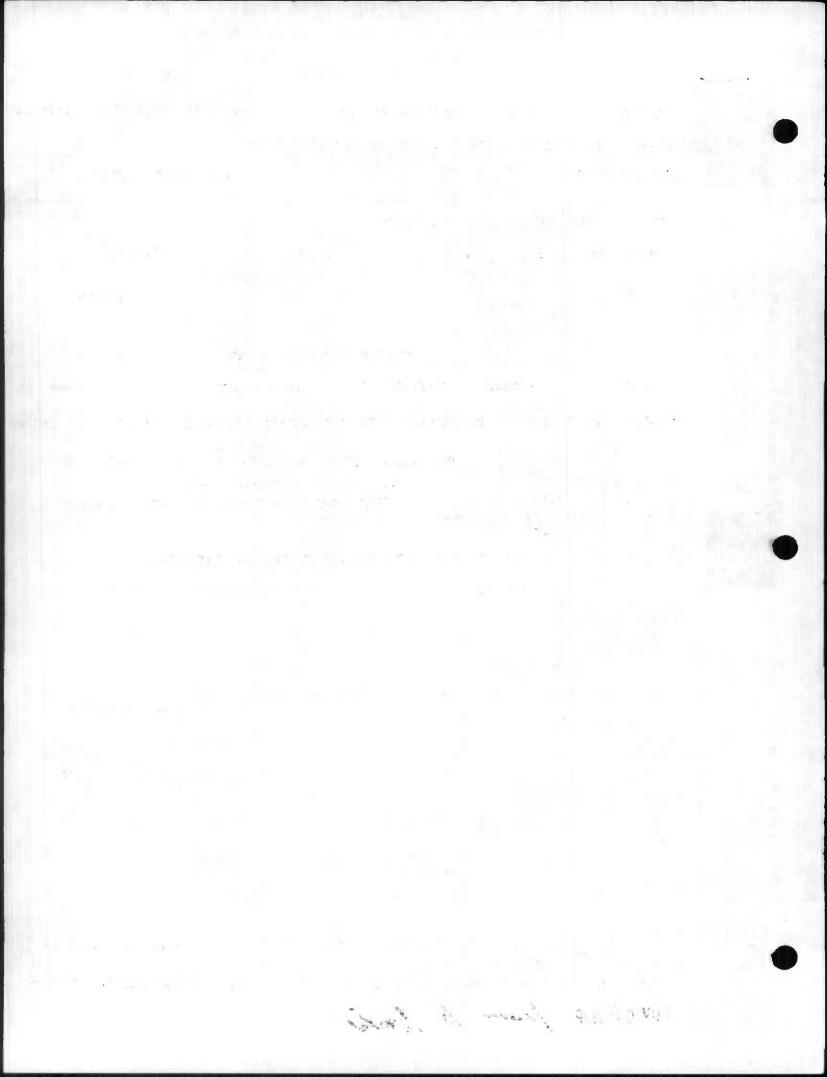
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MADURAL PRABHAKAR, M.D. - 2115 OLD OREMS RD., BALTIMORE, MD 21220

State Registrar 31. Date filed (Month, Day, Year)





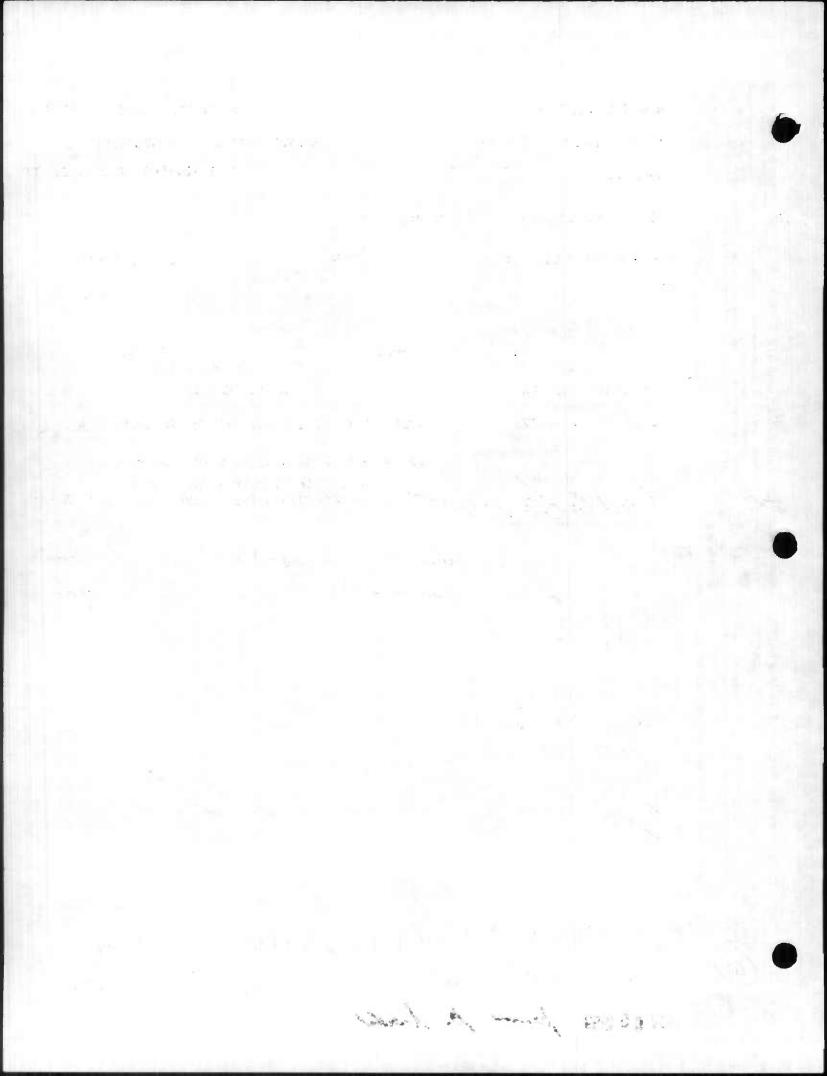


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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** IRIS MAE WOODFOLK 10:30am NOVEMBER 2,1999 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 11628 STEWART LANE #104 SILVER SPRING MONTGOMERY 8. Dete of Birth (Month, Dey, Yeer) JULY 18,1943 If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country)
 WASHINGTON DC 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 10 M 25 F Deys Hours Min 56 Yrs. 578-58-5893 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frems 23a or 28a-f show traumatic event, the Medical Examines must be notified at 6 0/6 XXYes 2 No MD MONTGOMERY SILVER SPRING Direct 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11628 STEWART LANE #104 20904 Funeral UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours effer department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten sny injury or other traumetic event, the Medical Examinations. XX Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PRIVATE NURSE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ANTHONY WOODFOLK LOUISE HARRIS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DORIS COLE / SISTER 13214 STRAVINSKY TERR. SILVER SPRING, MD 20904 20b. Pleca of Disposition (Neme of cametery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 Deuriel 2 Cremetion 3 Removal from State GEORGE WASHINGTON CEM. 11-8-99 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
ALEXANDER S. POPE FUNERAL HOME 21. Signature of Funeral Servica Licansee 11315 LOCKWOOD DRIVE, SILVER SPRING, MD 20904 at caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Quete myoundial infantim Examiner mellitus Examiner distretes ettending physician and for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest Due to (or as e consequenca of): Box 68760 Physician/Medicai Due to (or as e consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 | No 3 | Probably 4 | Unknown Division of Vital Records, P. þ 24b. Were eutopsy findings eveileble prior to been si 24a. Wes en eutopsy performed? Completed Carcinemel completion of cause of deeth? hes le 2 certificate her 1 ☐ Yes 2 12 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examined? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending 1 PNaturel n 24 hours efter death.

Ne Funeral Director: At pletely filled in by the ft death. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of 29d. Date signed (Month, Dey, Year) 99 6 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) FERRARA Rosen MW) lar 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) State Registrar NOV 0 5 1999



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** Harvey S. White November 3, 1999 12:05 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Sears Manor Assisted Living Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | Min. | March 5, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 579-09-0566 1918 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Matical Examiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's Hyattsville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 6111 39th Place 20782 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mentel Hygiene. Important: if itsm 27 is marked other than "natural", or he any injury or other traumatic event, trained as any injury or other traumatic event, trained as any injury or other traumatic event, trained as any endown. 1 XYes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 C & P Telephone Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 20 Wilmer White Bertha Alfauter 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Aradina M. White - Wife 6111 39th Place, Hyattsville, Maryland 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Cedar Hill Cemetery 11/06/99 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the deeth. Donot enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final · BISPIRATURY disease or condition resulting in death) 24 1+ns PATLL Examiner Due to (or es e consequence of): Examiner DEDRAIDA that the death certificate be executed physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): 68760 Physician/Medical Due to (or es a consequence of) for use es Box signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whknown Records, à The lew requires 24b. Were eutopsy tindings eveilable prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificata Division of Vital al or Attanding Physician: To sefter death.

I Director: After this certificat of in by the funeral director, p Be 25. Wes case referred to medicat examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1755157137 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Vetural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled I Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 1127838 November 5, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Hem 23a) (Type, Print) 21090 518 CAMP MIRADIR QUAD, LIAITHICUM, MO TOHNI SIMPL Ens 32 Registrar's Signeture 31. Date filed (Month, Day, Year) NOV 0 5 1999 State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** November 2, 1999 9:30 pm Lillian E. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Genesis Woodside Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1□M 2XF 83 577-10-3847 Director Nov. 29, 1915 Washington, DC Usuel Residence of Decedent deeth with the Maryland 10b Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at 1 X Yes 2 □ No. Director Prince George's Maryland College Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4617 Fordham Road U.S.A. 20740 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: py 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health end Mental Hyglene. Important: If Item 27 is marked other than "nu any injury or other treumatic event, the Methal PAGE. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Harry G. Sims Amelia Webber 19e. Informent's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Yech - Husband 4617 Fordham Road, College Park, Maryland 20740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 11/03/99 Alexandria, Virginia 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, 20781 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last and Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. Yes 2 No 3 Probably 4 Unknown been signed t should be det Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed obonchive Leup dissare 1 Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 8 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 2 Accident 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigetion after deetl Director: the Funeral Director of the Fu 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde Hospitai Medical (Check only one) Scertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 3, 1999 pleted cause of death (Item 23a) (Type, Print) Research BLVD 2401

**DHMH 16 Rev 6/95** 

State Registrar 31. Date filed (Month, Dey, Year) NOV 0 5 1999

32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMENDED #23a, PER MD, G777, 11/18/99 DH 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** NOVEMBER 05 1-1:10 Saac /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number, 4c. County of Death Examiner HOSPITAL OF BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number Birthplace (Stata or Foreign Country) 6. Sex **Funeral** 10 M 20 F 245-12-2929 Director Usual Rasidence of Decedant 10a. Stata 10b. County 10d. Inside City Limits 10c. City, Town or Location Annestronex, Yas 2 No Directo Md Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 USA 2710 Allendale 212160 Funeral 12. Was Decedent Evar in U,S.
Amed Forcas?
12 Yas 2 No
If Yas, Giva
Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. Nevar Married 2☐ Married specity: Black 1□ Yes 2□No Specify À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT use retired) KURDIN CES: 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) Bus MTA vear Driver marked other 17. Fathar's Nama (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be and Mental Armstrong Riddick Dona 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 515+e N. Fulton Baltimore, MO tordbey mportant: If item 27 any injury or other to brothy 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 8 → Burial 2 Cramation 3 Ramoval from Stata Nov. 10 arrisonForcest Veterans 4 ☐ Donation 5 ☐ Othar (Specify) Owings Mills 22. Nama and Addrass of Facility Nutter 21. Signature of Funeral Service Licenses Funeral Homes, Inc. 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failure. List only one cause on each line. 21216 Physician Pneumonia /Medical Immediata Causa (Final Aspuration 25 minutes disaasa or conditior rasulting in death) Examiner Dua to (or as a consequence of): Examiner LUNG CARCINOMA Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaase or Injury Due to (or as a consequence of) physician the buria COPD Box 68760. Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequance of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown wha COVCURONAL Records, edical Certification: To Be Completed by 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 No of Vital 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 2 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Mannar of Death

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2 Accidant 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Division or Attending 5 Panding Invastigation death. 1 Yas 2 No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifiar 29b. Signature and title(5) 29c. License number 29d. Data signed (Month, Day, Year) KEG 030 30. Nama and address of person and completed cause of death (Item 23a) (Type, Print) BALTIMORE W. BELVEDELL MIGHELE D. MENNETTE HID 20215 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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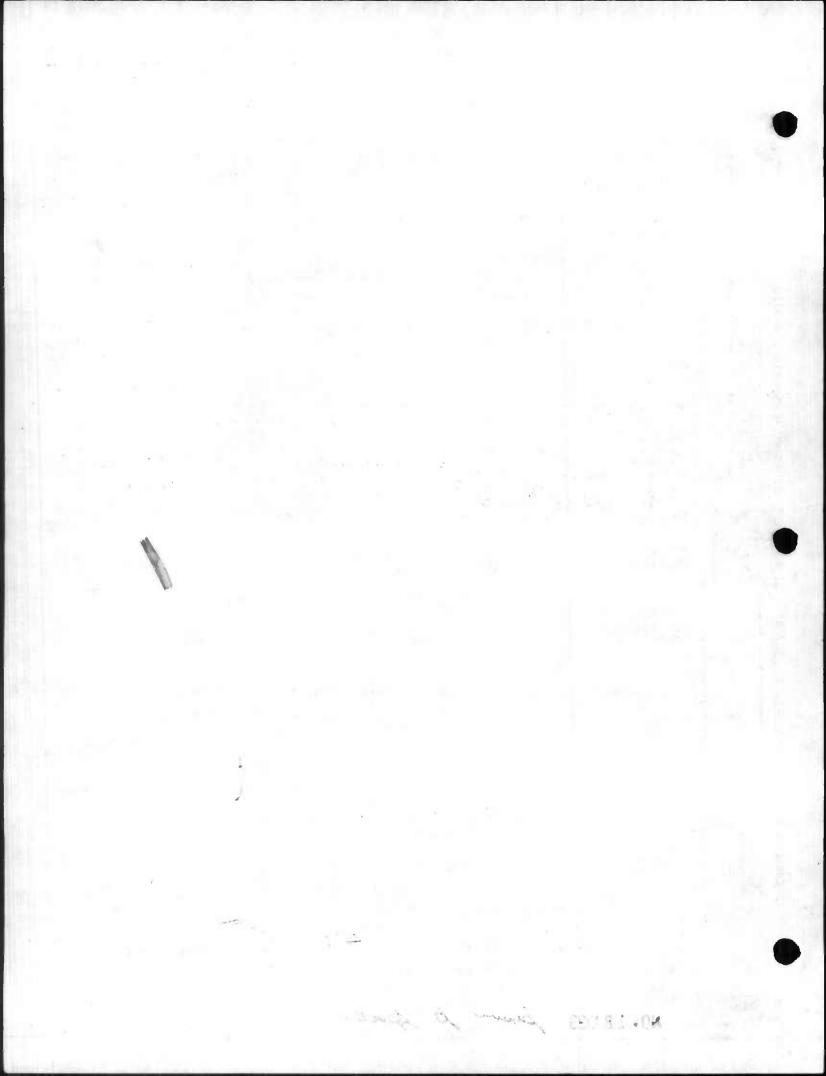
State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year Physician CATHERINE ASHBURN 1:40 P.m. MOVEMBER 16 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JATI920H HARBOR BALTIMORE CENTER n/a Hours Min. 8. Date of Birth (Month, Day, Year) March 19, Birthplace (State or Foreign Country)
 Ilaryland If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2ØF 84 Yrs. 1915 Director 218-10-6750 Usual Residence of Deceden the Mandend 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours etter death with i end of Health and Merial hyglane.

and if Nem 27 Is marked other than "natural", or frems 23s or i usy or other traumfile event, its Merial. 5105 Patrick Henry Drive 21225 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White py 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 Jacob Goldberg Schuminisky Hanna L. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana Ashburn - Daughter 2 Dunlap Court, Pasadena, MD 21122 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Nov. 18 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Se 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each time. Approximate tnterval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Cardiac vac Arry Himias 2 days Examine Examiner 3 days LMAB DO MYOLYSIS physician and s the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 980 signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificate has b 1 Yes 2 No 1 Tes 2 No Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: At completely filled in by the fu 1 Yes 2 No deeth. 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P13472 Kaulan 16h 1999 M.D NOVEMBER Bait mD 21225 Ospital Center 3001 So Hanover St 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SANDEEP GAUTAM Harbor 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State

NOV 1 8 1999



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM 10	ЭЬ Р	ER FH G777 11/18/99 AH	State of Marylan	id / Department of Certificate of		ntal Hygiene Reg. No.	99	36163
		1. Decedent's Name (First, Middle, La	st)	-	2.	Date of Death Month Dey	Year	3. Time of Death
Physi /Med		James	Bright	10.		11 16	9	9 7:00 p.M
Exam	iner	4a. Facility Name (If not institution, giv	1 / 1		4b. City, Town, or Locat		County of Deal	th O O
		5. Social Security Number 6. S	Sex / 7. Age (In yrs.	lest birthdey) If Under 1 Yea	Catorsvi ar if Under 24 Hrs. 8	Date of Righ		Trivore
Funera Directo			M 2□ F	20 Yrs. Months Dey	s Hours Min.	Date of Birth (Month, Day, Year)	919 Pen	thplace (State or Foreign ountry)
		Usual Residence of Decedent	11/0	0		41.	0,110	
h the Merylen r 28a-f show	_	10a. State 10b. County	N/A 10c. Cit	y, Town or Location				10d. Inside City Limits
the M	ecto	Mary and Burnber	771107-0	Baltimor		10.00		1 ☑ Yes 2 ☐ No
ith with 23a or	급	77.7 Storece	ICH Rd. And	10f. Zip Code	21279	10g. Citiz	en of What Co	Junity?
d 21215-0020 filed within 72 hours effer death with the Meryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examinet must be notified at	by Funeral Director	11. Marital Status	12. Wes Decedent Ever In U. Armed Forces?	,S. 13. Was Decedent of	Hispanic Origin? (Specify than, Mexican, Puerto Ric	Yes or No- 1	4. Raca - Ame	/   erican Indian,
Or its	Ē	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give	If Yes, specify Cu			Black, White	e, etc.
21215-0020 d within 72 hours eff piene. r then "neturel", or the Medical Exem	d b	3 ☐ Widowed 4 ☐ Divorcad	Year or Dates:				Specify: 13	acq
15- n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade com <i>pleted)</i>	16a. Decedent's Usuel Occ (Give kind of work don life. DO NOT use retii	upation be during most of working	16b. Kin	d of Business	Industry
212. d within	dmo	Elementery/Secondery (0-12)	College (1-4or 5+)		TerK	Ad	Minist	-ration
offied other	Be	17. Father's Name (First, Middle, Last,	1101		18. Mother's Name (F	irst, Middle, Maiden S	Sumeme)	
arylandshould be in marked of urmatic eve	5	Oder Bi	ightful		Beatrie	e Dunso	7~	
	1	19a. Informent's Name/Relationship (	Type, Print)	19b. Mailing Address (Street	et and Number or Rural R	oute Number, City or	Town, State, 2	Zip Code) 422
ore, M es 1 end 2 of Health item 27 li		Many Brightfu	4-Wife	Place of Disposition (Neme of	creft Kd.	Apt. F C	saffin	ore, Marykin
Baltimore, semil. Peges 1 el Popariment of Hea mportant: if Item inny injury or othe		20a. Method of Disposition	Removal from State	emetery, crematory or other p	laca)	Date 20c. Loc	cation - City or	Town/State
Baltimo pemit. Pege: Department of important: If i		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		22. Name end Add	Vet. Cem.	100 Days	VI	Maryiana
Balt permit. Departr importa	MIK	Levi-	Park	25. Name and Add	Test of Pacifity REVI	VA. Tar	Ker Fi	meral Hom
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	h. Do not enter the mode of d	ying, such as cardiac or re	espiratory arrest,	altimo	Approximate Interval Between
Physician	,	Shock, or heart failure. List only	one cause on each line.				1	Interval Between Onset and Death
/Medica Examine	_	Immediate Cause (Final disease or condition	Seps	}				are
Examine		resulting in death)	Due to (o	r as a consequence of):				17
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68760, ificete be executed physician end es the buriel-transit	dicai	thet initieted events	c. Due to (or	r as a consequence of):				
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O de des	ysic	Pert II. Other significant conditions of	ontributing to death but not resi	ulting In the underlying cause o	given In Part I.	23b. Did tobacco u	se contribute	e to the cause of death?
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Division of Vital Records, P.O. or Attending Physician: The law requires that the dieffer deeth.  Director: After this certificate hes been signed by the ding type tuneral director, page 2 should be deteched	d by		· Candre	arrhy thing	P	24a. Was an autops	sy 24b.	Were autopsy findings
s bee	ojete		-			performed?		available prior to completion of cause of death?
Re la The la te hes	Completed					1 ☐ Yes 2 ☐		1 ☐ Yes 2 ☐ No
of Vital Rec nysician: The law his certificate hes I	BeC	25. Was case referred to medical examiner?			26. Place of Death (C			
of V hysic his ce	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	EH/Outpatient 3 DOA		5 ☐ Residence 6	□Other (Spe	icify)
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ISIC ttend deeth deeth ttor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	Location (Street and	Mumber or B	ural Poute Number
Div A ster of the by	erti	4 ☐ Homicide determined	building, etc. (Specify	ome, farm, street, factory, office	201.	City or Town, State)		arai Noute Number,
spita hours neral		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, death occurred at the	time, date end place, and	due to the cause(s) a	and manner as	s stated.
Division of Total or Attending Physical Physical Physical Physical Physical Process of the Paneral Director: Affer thi compierely filled in by the funeral	edical	(Check only 2 Medical Examone)	niner: On the basis of exeminer and manner stated.	tion and/or Investigation, In my	opinion, deeth occurred a	at the time, date and	place, end due	to the ceuse(s)
To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	AH	29c. Licer	nse number	29d. Dete	signed (Mont	h, Dey, Year)
W/s		BULL		mb. 1)?	16742	17	3 V /	1,77
		30. Name and address of person who	completed cause of deeth (Item	23e) (Type, Print)	86942 Rd Bollin	on, so	2122	7
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signe		- 3 -7.			•
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED #23aPER MD, G777 11/18/99 DH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 3:05 AM Betty Jean Brown October 30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 N F Months Davs Yrs. 220-24-1038 Director Baltimore.MD. Feb. 2.1928 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show must be notified at 1 Yes 2 No Director 289-1 Maryland Baltimore Kingsville 8 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a or 12301 Stoney Batter Road 21087 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: þ 72 hours 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 11 yrs. n/a Housewife Home Department of Health and Alental Hy Important: If them 27 is marked other any Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 98 Rosco Jones 20 Agnes Hamilton 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Emory Brown (Husband) 12301 Stoney Batter Rd. Kingsville, MD.21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/2/99 Baltimore, MD. Metro Crematory 21. Signature of Funeral Service Liceral 22. Name and Address of Fecility E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, MD. 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) wich Examiner 1 wk ASPIRATION PNEUMONIA physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 SEPSIS 1 wkPhysician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown PARKINSON Disease, seizure Disorder þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an eutopsy performed? Completed page 2 s hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complataly filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature october 30th 1999 Httending 16444 30. Name and address of person who completed cause of death (Nem 23a) (Type, Brint) VIJAV. - S. NAIR M.D. 2112 Belair Road. Tallstan. MD21047

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, D. NOV

V 1 8 1999

32. registrar's Signeture

Jenn B. Janes

novi s 1999

# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36165 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Nov. **Physician** OTLIST 9:05 AM OTIS BRYANT 16 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8, Data of 1522 MCKEAN AVENUE N/A 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours XXM 2DF Yrs. Director 220 64 3795 08/11/1955 NC Usual Rasidence of Decedant death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow than "natural", or items 23s or 28s-f shorthe Wedical Examiner must be notified at Yas 2 No MD N/A Funeral Director BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1522 MCKEAN AVENUE 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indien, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after Hygiana. other than "natural", or its 1 ☐ Yas 2 No If Yas, Giva 1 Never Merried 2 Married Specify: BLACK 1 Yas 2 No Specify: 21215-0020 þ 3 ☐ Widowad 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Haath and Mental Hygian Important: if Item 27 is marked other th, any Injury or other traumatic event, the once. LABORER 11 CONSTRUCTION Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be CHARLIE BRYANT ETHEL WILKINS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) LOIS DAVIDSON/SISTER 3710 ARCADIA AVENUE BALTIMORE, MD 21215 20a. Mathod of Disposition

1. Burial 2 □ Crametion 3 □ Removal from Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Dete 4 Donation 5 Othar (Specify) CALVARY CEMETERY 11/20/99 BALTO., MD of Funeral Service Licensee 22. Nama and Addrass of Facility JAMES A. MORTON & SONS F.H., 1NC 4 1701 LAURENS ST. BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat end Death **Physician** Immedieta Cause (Final disaasa or condition resulting in deeth) /Medical YEARS DUANCED Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, laading to immadiete causa. Entar Undarfying Cause (Disease or Injury that initiated evants resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical tha Due to (or es e consequance of): USB as Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes 2 No signed I of Vital Records, Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has paga 2 1 Yas 1 ☐ Yas 2 ☐ No Attending Physician: director. 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No Medical Certification: To this 28a. Data of Injury (Month, Day Year) funaral 28d. Dascribe how injury occurred 27. Mannar of Death

1 Death

1 Accident 28b. Time of Injury 28c. Injury at Work? Aftar f 5 Panding investigation Division after death. 1 ☐ Yes 2 ☐ No tha 6 Could not be detarmined To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledga, death occurred at the time, dete end plece, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred at tha tima, data and placa, and dua to tha cause(s) and manner steted. To the I within 2 To the F 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) Vasanthakuma NOV. 16, 1999 42510 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 21. N. EUTAWST 407, MDZ1201 VASANTHA KUMAR

State Registrar

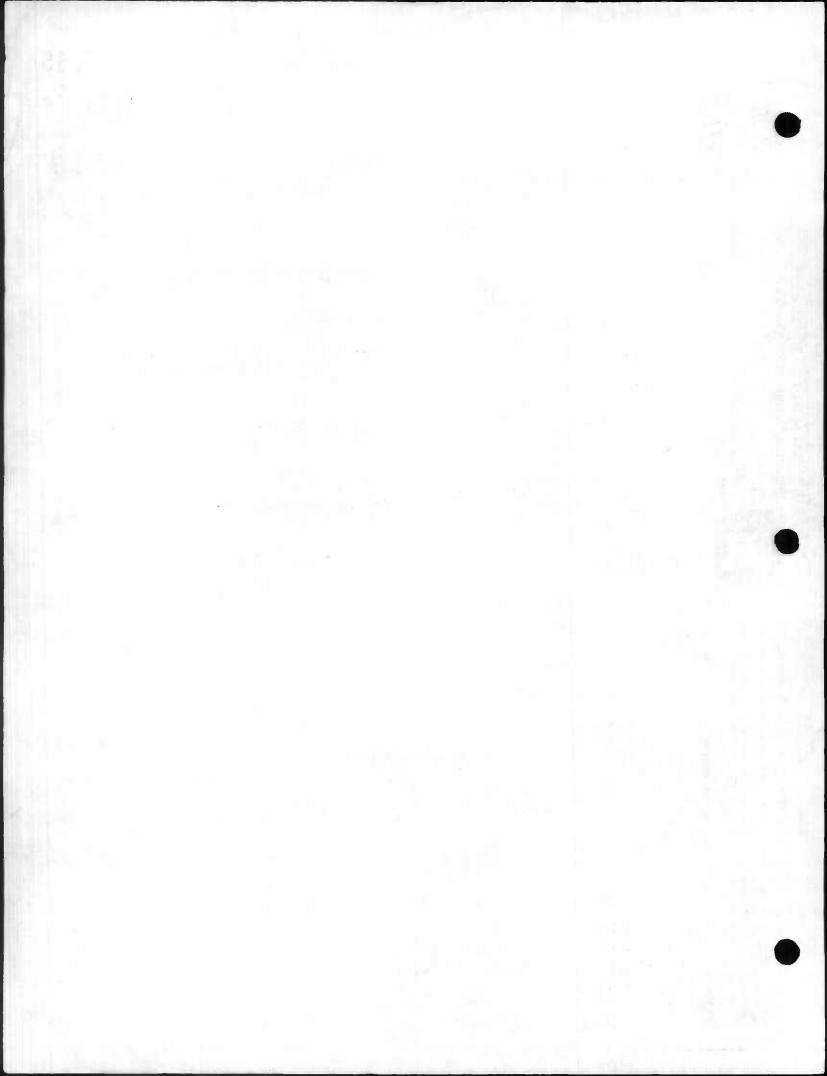
DHMH 16 Rev 6/95

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31. Data filed (Month, Day, Year) NOV 18 32. Registrar's Signatura

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**ORIGINAL** 



Physician Box 68760 Records, P.O. Division of Vital

physician end s the burial-trensit Medical

the Hospital or Attending Physician: nin 24 hours efter death. the Funeral Director: After this certifica npletely filled in by the funeral director, To the Hospital of within 24 hours of To the Funeral D completely filled I

Physician/Medical by Be Certification:

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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other traumatic event, the Medical Examiner rivest be

2 should be filed within 72 hours efter end Mentel Hyglene.

permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than "naturel", any injury or other traumatic avant

/Medical

**Examiner** 

Maryland 21215-0020

Baltimore,

Registrar

State

29a, Certifier (Check only one)

29b. Signature and title of certify

completed cause of deeth (Item 23e) (Type, Print)

C19 32. Registrer's Signeture

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

MARYLAND GENERAL HOSPITAL

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental HygieneQ Q Certificate of Death 2. Date of Death Month Year

1. Decedent's Name (First, Middle, Last) **Physician** BROOKS YRONE NOVEMBER 1999 /Medical 4e Facility Neme (If not institution, give street and number) 4h City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL (ENTER Hanbor If Under 1 Year | If Under 24 Hrs. | 6. Sex 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days MAM 2□F 220-66-1401 Yrs. 43 Director Aug 20, 1956 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumstic event, the Marical Examinar must be notified at Director MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Bridgeview Rd Apt A 21225 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yas 2 No If Yes, Give XX Year or Dates: 1 ☐ Never Merried 2 ☐ Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiane. Important: If Item 27 Is merked other than "n any Injury or other traumetic event, me mean Elementery/Secondery (0-12) College (1-4or 5+) Insulator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Lo Lionet Jones Margaret Loretta Turner 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aletha Brooks/spouse 607 Bridgeview Rd Apt E Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service lineases. Wade, Director 22. Nams and Address of action Board 655 W. Baltimore Street Baltimore, MD 21201 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** ASPIRATION PNEUMONIA
Due to (or es a consequence of): /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner CELEBROVASWIAL ACCIDENT Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avants resulting In death) Last Due to (or as a consequence of): physician is the burial Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

3. Tima of Death

10d. Inside City Limits

1 Yes 2 No

9.10 PM

24a. Wes an autopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

25. Wes case referred to medical examiner? Hospital: 1 Yes 200 No N☑Inpatient 2☐ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.

29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signatura and titla of certifier AS2441614 A34 November 11 Boddeti MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN URAO HA BODOETI 3001 S. HANOVERST.

State Registrar

signed by the aid

Division of Vital

or Attanding Physician: after death. Director: After this carifice

Hospital or / 24 hours aftar Funeral Dire pletaly filled in the

within 2 To the

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31. Dete filed (Month, Day, Year)

32. Registrar's Signature doorte

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State of Maryland / Department of Health and Mental Hygiene 99 36 | 68

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		's Nama (First, Middle,	Last)						2. Deta of D		Year	3. Tima of Death		
Physician /Medical		S	tewart H	Huber	Cart	er			NOV	15 19		8:15 F		
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		burg Luth	eran Hon	ne				Pikesv	ille	Ва	ltimo	re		
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natural'.		15. Decedent's (Specify only highest			16a. Dec	cedent's Us	sal Occup	ation	ndkina	16b. Kind of I	Business/Inc	dustry		
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marked other marked other To Be Cc		Thomas V	ance Car	rter				Sac	lie Hub	er				
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Item 27 other to	20a. Method	of Disposition		20b. I	Plece of Dis	position (N	me of	201	Date	20c. Location	- City or To	wn, State		
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01 60		death) Last	d	Due to (c	Due to (or es a consequence of):									
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**ORIGINAL** 

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sician edical	(ייף	Thomas Gridley Casey II							Octobe		1999 11:25	
niner	4a Facility	Nama (If not insti	itution, give	street and number	or)			4b. City, Town, or L			y of Death	
		orial H	ospit	tal				Cumberla	and	Alle	gany	
l r	214-4	ecurity Number	-				If Under 1 Year Months Days		8. Dete of Birt (Month, Da 4-14-1	y, Year)	9. Birthplace (State or Fo	
or 28a-f show be notified at Director	10a. State	dence of Deceder			10c. City	y, Town or Lo		10d. Inside City L				
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Director	MD Allegary Mount Savage  10e. Street and Number 10f. Zip Code									10g. Citizen of	What Country?	
il, or tems 23s minor min by Funeral	1552	5 Stati	on Ma	aster F	Row		21545			U.S.A		
	11. Marital	Status ver Married 200	Married	12. Was Deceder Armed Force 12 Yes 2 [ If Yes, Give	2. Was Decedent Ever in U,S. Armed Forces?  1X Yes 2 □ No			Hispanic Origin? (Sp san, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra	ce - American Indien, ack, Whita, atc.	
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Be Completed	17. Father	12 4 Environmental Sanitaria 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First,										
TOB	Thomas Gridley Casey Gretchen Wanner											
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Tox										n, State, Zip Code)	
		E. Wa	rren	(Wife)			Box 490	Mt.Sar		MD 21	545	
		d of Disposition rial 2 Creme	tion 3 □R	emovel from Sta	~	Mace of Dispo- cemetery, cren	sition (Name of natory or other pla	ice)	Dete	20c. Location	- City or Town, State	
		onation 5 Oth					c Gift		10/7/9		Laurel, MD	
	21. Signat	ure of Funeral Sei	rvice License	96		22	. Name and Addr	ess of Fecility Ana	atomic	Gift	Foundation	
Department of Health and Mental Hyglena. Important: If item 27 is marked other than any injury or other treumstic avent, the Menca.  To Be Complete.		12		1		11	3948 Ba	ltimore	Ave.	Laur	el, MD 2070'	
	23a. Pert1 shock	Enter the disease, or heart follows	List only or	that cause on each	ed the death line.	h. Do not ente	er the mode of dy	ing, such es cardiac	or respiratory a	rest,	Approximete Interval Betwee	
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cal Examiner	if any, leading to immediate											
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61	1. Decedent's Name (First, Middle, Last			rtificate c		2. Dete of De Month	Dev	Veer	me of Death	
Physician /Medical	'EWAN CH	AMBERS		NOVEMB	ER 15	, 1999 9	.409			
Examiner	4a Facility Name (If not institution, give UNION MEN	street end number) 1021AL Ho	SPITA	L	BAI	Location of Death	E N	/A		
Funeral Director	5. Social Security Number  220-46-8495  Usual Rasidance of Decedent	7. Age (In yr	s. lest birthdey) Yrs.	If Under 1 Ye Months De		8. Date of Bin (Month, De Decembe	r 8,191	9. Birthplece (S Country) Canac	lete or Foreign la	
ahow id.at	10a. Stete 10b. County		City, Town or Lo	ocation				10d. insi	de City Limits	
tor	Maryland Baltimo	ore	Balta	imore				1 🗆	Yes 2₹ No	
r items 23s or 28s-fs obsermant be notified Funeral Director	10e. Street and Number 28 Over Ridge Ct.	REPORT L	10f. Zip Code 10g. Citizen of Whet 21210 United Si							
by E	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 XYes 2 □ No If Yes, Give Yeer or Dates: 194.		Wes Decedent of If Yes, specify C 1 ☐ Yes 2 🔀 I	of Hispanic Orlgin? ( Juban, Mexican, Pue No Specify:	Specify Yes or No into Ricen, etc.)	Blac	ck, White, etc.  white	an,	
Completed	15. Dacedant's Edi (Specify only highest gred Elamantary/Secondary (0-12)	cation de completed) Collage (1-4or 5+)			cupetion ne during most of w tired)	orking		usiness/industry		
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aumatic e	19a. Informant's Name/Relationship (T		19b. Mail	ng Addrass (Str	eet end Number or F					
T T	Laurette Chambers				dge Ct.	Baltimo	re, MD	21210		
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Important: if any injury o once.	21. Signetura of Funeral Service Licens  Dona d. Mui	tchill I	2	2. Nama and Ad	drass of FacilitMi 65 Ba	tchell-W 00 York l 1timore,	Rd.		Home, I	
Physician and strength is the buriel-transit and and and and and and and and and and	Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants	Due to	2 AT) (or es e conse	quence of):	NEUM	ONIA.		1	day	
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• Funera eletety fille edical (	29a. Cartifiar (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of my kiner: On the basis of exami end menner steted.	nowladga, daet nation and/or In	h occurred at the	a tima, date and place ny opinion, daath occ	ce, and due to tha currad at tha tima,	causa(s) end made,	annar es stetad. and dua to tha ca	usa(s)	
Toth	29b. Signature end title of certifier  Mana Da L	Sedds	M.		ense number - 243 l	8946		ber 15 D		
	30. Name and address of person who come MAMATHA & SADDA			20.5						
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sig	nature	lon	11110,		, , ,	MD -	212/	



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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental HygieneQ Q 36171 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 7:38 AM 4c. County of Death 4a Facility Nama (If not institution, give street and number 4b. City, Town, or Location of Death BON SECOUR BALTIMORE N/A If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days Months 1 M XXF Yrs. 213 30 0779 65 06/10/1934 MD **Usual Residence of Decedent** 10c. City, Town or Location 10a. State 10b. County 10d. Insida City Limits N/A BALTIMORE 1 ♥ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1601 SPRAY CT. 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☒ No If Yas, Give Year or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 DAYCARE PROVIDER CHILDCARE 17 Father's Nama (First Middle Last) 18. Mother's Nama (First, Middle, Maidan Sumama) ROBERT JONES ESTELLE COOK 19e. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) OLIVER CHANEY/HUSBAND 1601 SPRAY CT. BALTIMORE, MD. 21217 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cremation 3 □ Removat from Stata GARRISON VET. CEM 4 ☐ Donation 5 ☐ Other (Specify) 11/19/99 OWINGS MILL, MD 22. Name and Addrass of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service License mes a LAURENS ST., 1701 BALTIMORE, MD. 23a. Part. Inter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, show or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final opernoma disease or condition resulting in death) Hes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? complation of cause of death? 200 No 1 ☐ Yes 1 ☐ Yas 2 ☐ No 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 DER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Naturat 1 Yas 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be

Examine physician and the burial-transit The law requires that the death certificete be executed Box 68760. Physician/Medicai 980 signed by the a þ should Completed page 2 90 or Attending Physician: funeral director, Be Certification: To After this efter death. filled in by

**Physician** 

/Medical

Examiner

MD

Director

Funeral

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Completed

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**Funeral** 

Director

28a-f å

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Pages 1 and 2 should be nent of Health and Mental

important: If Item 27 any injury or other to

**Physician** /Medical

Examine

filed within 72 hours after

Baltimore, Maryland

P.O. Records. Division of Vital Hospital To the Hosp within 24 hos To the Fune completely fi

> State Registrar

**DHMH 16 Rev 6/95** 

24 hours

Mitu DAVE 31. Data filed (Month, Day, Year) NOV 18 1999

4 Homicide

(Check only one

29e. Certifier

29b. Signature and title of certifier

- 0 444

29c. License number 1903

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

99

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

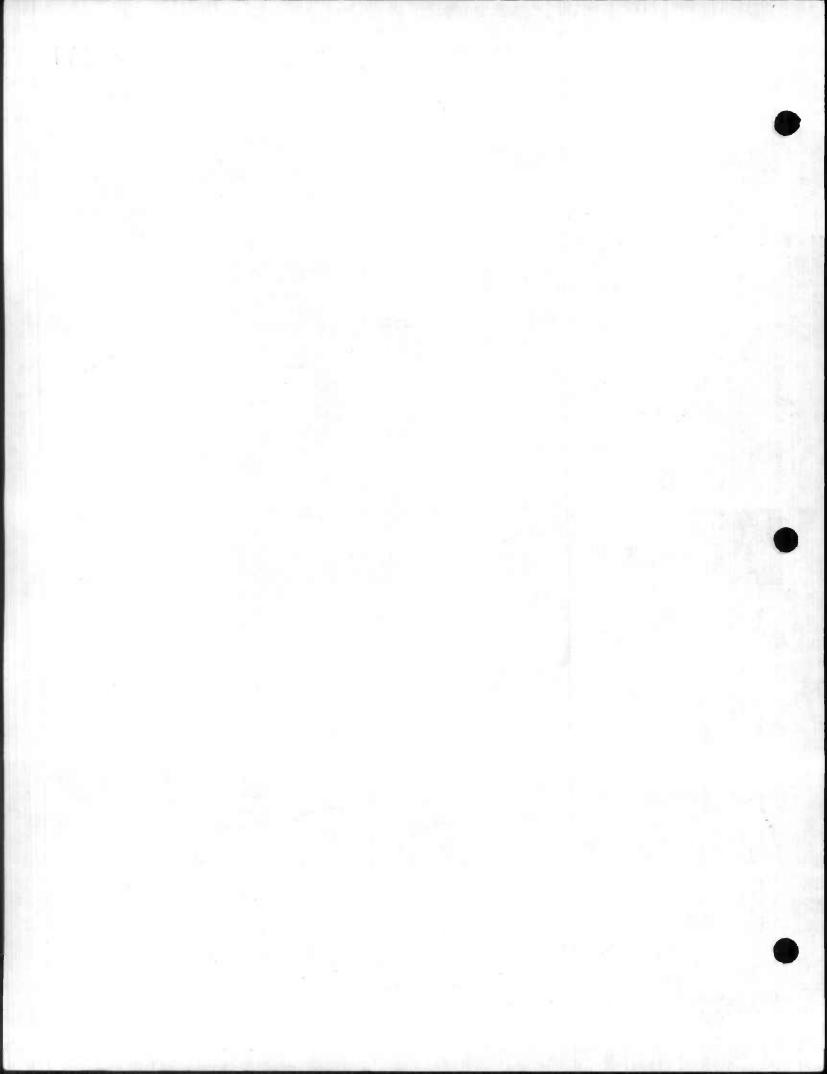
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32. Registrar's Signatura

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

w. Baltimore St. Baltimore, Md 2:223 2000

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle Last) 2103 November 10 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Trunder 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) RMOI MOIN 5. Sociel Security Number 6. Sax Birthplece (State or Foreign
 Country) Months Deys 10 M 20 F 218-42-438 Usual Residence of Decedent Yrs. VICSINIC 10a. Stete 10b. Count 10c. City, Town or Location 10d. inside City Limits 1₽Yes 2□No Id timbre 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 32 12. Was Decedent Ever In U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Merital Status Bleck, White, etc. 1- Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: CCK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working UKN
life. DO NOT use retired) 16h. Kind of Business/Industry **UKN** Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) trancis 20 MOU 19a, Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Stete, Zip Code) 3 2 alver 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 □ Donetion 5 □ Other (Specify) Cremator Part. Anter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21. Signature of Funeral Service Licensee Approximate Intervel Between Onset end Deeth immediate Ceuse (Final disease or condition resulting in deeth) days Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 200 No 1 Yes 2D-No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Sympatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27 Manner of Deeth 1 Daturel

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or ite, any Injury or other traumatic event, the Medical Examina

Maryland 21215-0020

altimore,

Julius Dinki

the Marylend

Examiner Physician/Medical

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Completed

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2

Certification:

Medical

2 Accident

29b. Signature end title of certifier

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funerel director, page 2 should be deteched for use as the bunal-transit P.O. Box 68760. Division of Vital Records,

State Registrar

6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

5 Pending Investigation

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 2 🗆 No 1 TYes

Location (Street and Number or Rural Route Number, City or Town, Stete)

to Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29c. License number AT2438946 29d. Dete signed (Month, Day, Year)

30. Name and address of purson who completed cause of death (Item 23e) (Type, Print)

MACAYA DOUDGUIH Union Memorial

Hospital 201 East University Pkwy Baltimore mg

31. Date filed (Month, Dey, Year)

32. Register's Signeture

40418 1999 James & Source

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) 2/AM 4b. City, Town, or Location of Daeth 4c. County of Death 4a Fecility Nama (If not institution, giva street and number, GREEN E. WE ROJE If Undar 24 Hrs. N/A LONG 15 7. Age (In yrs. last birthday, 99 Yrs. Il Undar 8. Data of Birth (Month, Day, Y Jan. 28 5. Social Sacurity Number Birthplace (Stata or Foraign Country) Year) 3 1900 Months Days Hours Min 1□M 2♥F 220-46-7751 Jan. Canada Usual Rasidance of Decedent 10a Stata 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No N/A MORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 115 E. Melrose Ave. 21212 USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No ff Yas, Give Year or Datas: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. 11. Maritel Status Black, White, atc. 1 Naver Married 2 Married 1 ☐ Yas 2 ☒ No Specify: White Specify: 3 Widowed 4 □ Divorced 16b. Kind of Businass/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Giva kind of work dona during most of working life. DO NOT usa ratirad) (Specify only highast grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Medical Registered Nurse 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Neme (First, Middle, Last) John Aikens MacLeod McDonald Annie 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Nova Scotia Canada Eagles Funeral Home Westville, 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Ramovel from Stata 11-20-99 Nova Scotia, Canada Gladstone Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Fyheral Solvice Lines 22. Nama and Addrass of Fecility
Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or complication that come disease. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. Let only one ceuse on each line. Approximete Intarval Between Onsat and Death Immediata Causa (Final diseasa or condition resulting in deeth) Neumonia Dua to (or as a consaquanca of): Sequantially list conditions, if eny, laading to immadiata ceuse. Enter Underlying Ceuse (Diseese or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consaquance of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to madicel 26. Placa of Death (Check only one) axeminar? Othar: 4 Aursing Home 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 28c. Injury et Work? 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 1 Natural 5 Panding 1 Yes 2 No invastigation 2 Accident 3 Suicida 6 Could not be 28f. Location (Street end Number or Rurel Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide

Examiner ician and burial-transit The law requires that the death certificate be axecuted physician s s the burial Box 68760 ed by the a o. signed by I Records, Completed peen s certificate has b Division of Vital i or Attending Physician: after death. Director: After this certifica funeral director, the filled in by To the Hospital within 24 hours a To the Funerel Completaly filled

Physician/Medical

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Certification:

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29a. Certifier

29b. Signature and time

and address of person who cou

**Physician** /Medical

Examiner

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinat must be nothed at

filed within 72 hours after death with Hygiena.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other treumatic event.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

the Maryland

State Registrar

31. Data filad (Month NO

115 E. Melrare M.D. 32. Registrer's Signature

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ad ceusa of daath (Itam 23a) (Type, Print)

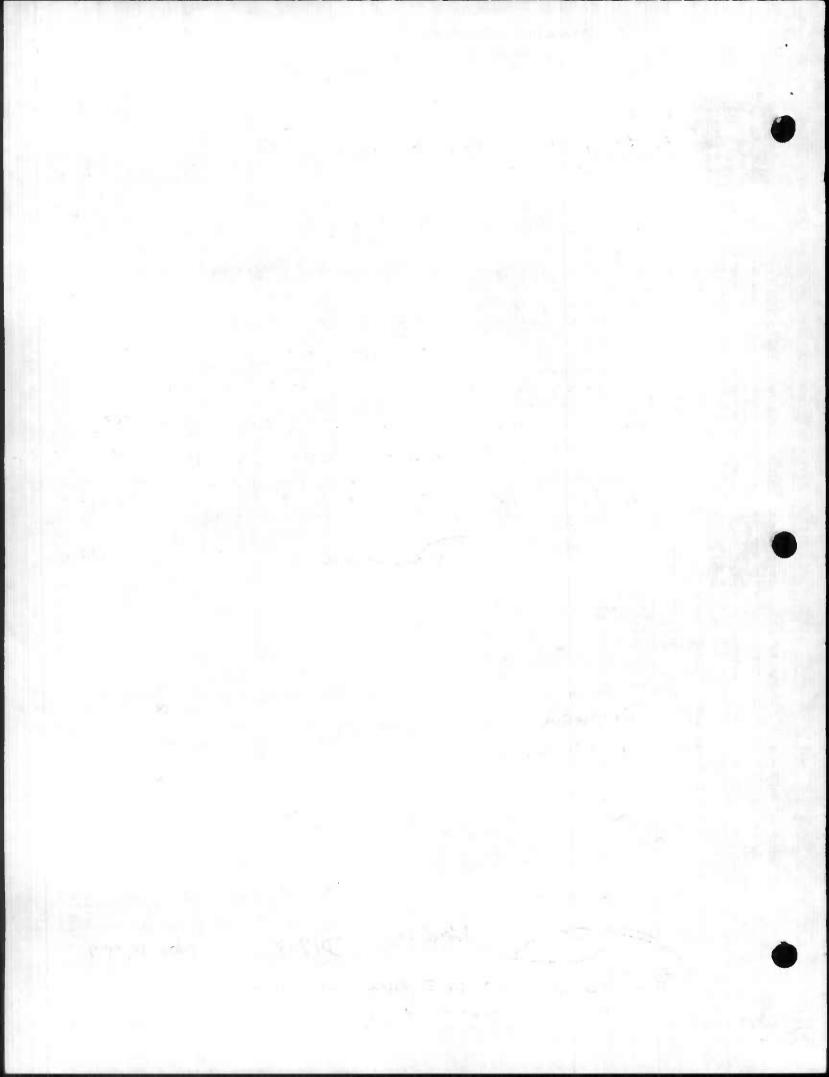
Certifying Phyelcian: To the bast of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the bast of axamination and/or investigation, in my opinion, daeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

18,1999



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

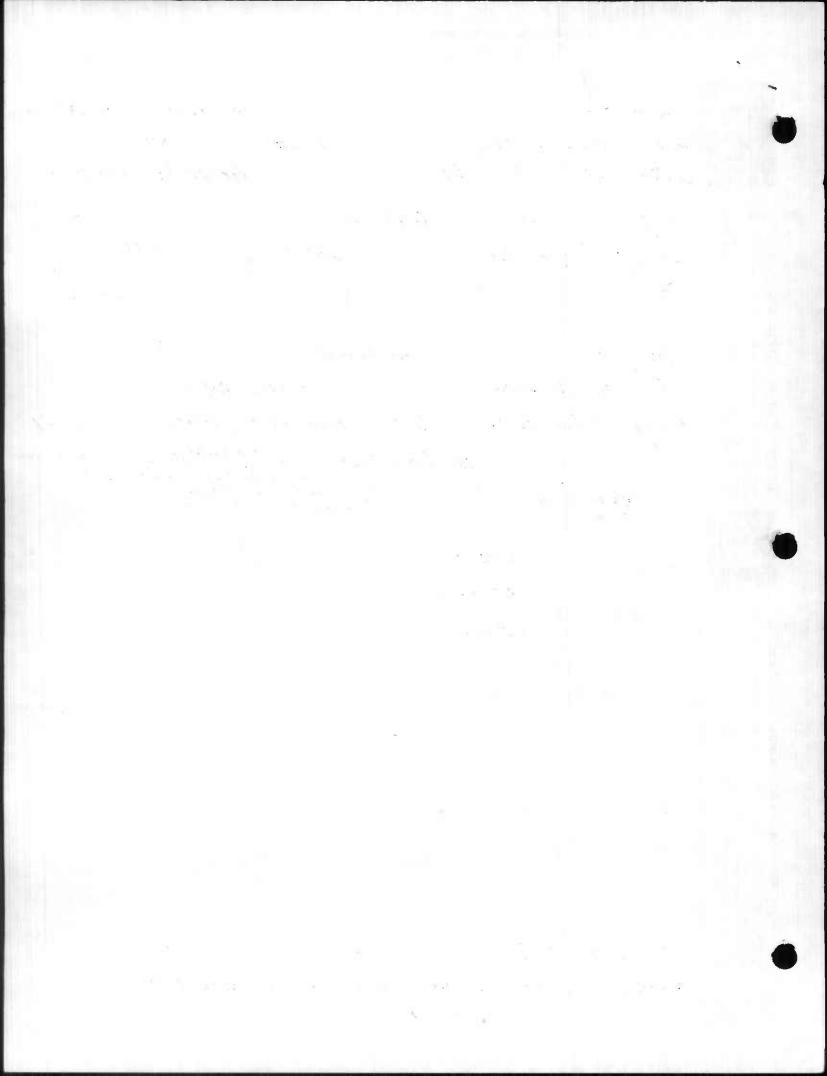
36174 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** :50 pm OV ROLAND WII.BUR DUNKERLY 16 /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG. 2, GIEN BURNIE ARUNDEL COUNT HOSPITAL 5. Sociel Security Numbar 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1⊠M 2□ F Country) MARYLAND 215-07-7880 93 Director Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 701 MARLBORO ROAD 21061 U.S.A. Funeral 11 Meritel Status Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva A Yaar or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WELDER W.R. GRACE COMPANY Saltimore, Maryland 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental tant: If hem 27 is marked **JOHN** DUNKERLY GRACE BRYAN 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROLAND R. DUNKERLY- SON 701 MARLBORO ROAD, GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cametary, crematory or other place) 20c. Location - City or Town, Stata b 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 11/19/99 ELKRIDGE, MARYLAND MT. ZION CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licenses 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE., S.W., GLEN BURNIE, MD 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, speck, or learn failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition rasulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Diseesa or injury that initiated evants rasulting in death) Last Da to (or as a consequence of): The law requires that the death certificate be exe physician a Box 68760; Physician/Medicai Due to (or as a consequence of): 88 for use Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was casa rafarred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Panding 1 TYes 2 □ No 24 hours after death. investigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida the Hospital Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29e. Certifiar completely (Check only within 2 29b. Signature and titla of certifie 29c. License number 29d. Data signed (Month, Day, Year) 0033296 10 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) DUARTERFIELD ROAD, GIEN BURNIE, MY 21061 32. Registrar's Signature State Registrar

408 I to 1888 James & france

# Please Type or Print in Black indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Month Dey Year

	•				State Of	iviaiyiai	_			Death		Reg. No.	9 3	6175		
~	Diversity in		Decedent's Name (First, Middle, Last)     Dorothy Dotson								2. Date of De Month		Year	3. Time of Death		
	Physiciar /Medica	ı J									Octobe	r 13	1999	10:36 am		
	Examine	7-5 Tourney Harris (11 Tourney 10 Street Str								4b. City, Town, or			of Deeth			
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L	Funeral Director	5. Sociel Security Number 6. Sex 1 M P F 7. Age (In yrs. last birthday) 1 Months Deys Hours Min.  White Deys Hours										Countr	Egirla			
			10e. State 10	b. County	. 1.	10c. C	ty, Town or Lo					10d. Inside C				
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Maryland	end Men is marke		19a. Informant's Name	/Relationship (	-		19b. Meili	ng Addre	ss (Street	end Number or Ru	ural Route Numb	er, City or Town		Code)		
	of Health e stand 2 la cother train		Harvin	Dotson	150n		331	5:	BA	1100 CT		HILLIE		2123/		
Baltimore,	8025		20a. Method of Disposit Burial 2 Co	remation 3 [	Removal from St		Plece of Disponentery, cre	metory or	other pla	ept. Ch- Co	Date /0/20/	20c. Location	- City or Tow	Vicgina		
Balt	permit. Pega Department of Important: If sny Injury or ance.		21. Signature of Funera	al Service Licer	isee			240	REI.	STEPS for w	~ ROM	Ø	is p	11.		
		+	23a. Part1. Enter the di shock, or heart fa	sease, or com	plications that cau	used the dea	th. Do not en	ter the mo	ode of dyi	ng, such as cardla	c or respiretory e	rrest,		Approximete Interval Between		
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Records,	sw requisites the same of the	Completed						-			24e. Was	en autopsy ormed?	evai	re autopsy findings ilable prior to apletion of cause leath?		
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on of Vital	ing Physician: After this certific uneral director,		12 Yes 2 No 27. Menner of Deeth 1 Naturel 5	Pending	28e. Date of (Month,	28e. Date of Injury (Month, Dey Year)   28b. Time of Injury et Work?   28d. Descr								)		
Division	To the Hospital or Attending Physician: The is within 24 hours effer death. To the Fureral Director: After this certificate ha completely filled in by the funeral director, page	I III Cal	2 GxAccident investigation 3 Guicide determined investigation 4 Homicide investigation  28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)							1 ☐ Yes 2 ☐ No  28f. Location (Street end Number or Rural Route Number, City or Town, Stete)						
_	To the Hospital or within 24 hours efter within 24 hours efter To the Funeral Director completely filled in				niner: On the bas	is of examina				me, date end place						
	othe ithin 2 or the omple		29b. Signature and title	of certifier	and menne	r stated.		2	9c. Licen	se number		29d. Date sign	ed (Month, D	Day, Year)		
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	$\propto$	-	30. Name and address	of person who	completed cause	of deeth (Ite	m 23e) (Tvpe		5222	8		1110	11/			
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	State		31. Date filed (Month, D	Dey, Yeer)	32. Reg	gistrar's Sign										
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dayyth PM ent NOVEMBER 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Oct 30, 191 Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1₩ M 2□ F Months 80 Yrs. 218-09-0725 unknown Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Baltimore 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Millenium Health 2 Fayette Street 21223 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 21 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: Black unknown 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education grade completed) (Specify only highest College (1-4or 5+) Elementery/Secondary (0-12) unknown unknown unknown unknown 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sophie Brown/friend unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Fulleral Service Licensee. Wade, Director <sup>22.</sup> State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 wil Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ANOXIC ENcepha Immediate Cause (Final diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es a consequença of): lmal 00 that initiated events resulting in deeth) Last Due to (or as a consequence of) 91 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

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**Funeral** 

Director

Physiclan/Medical Examiner ettanding physician and for use as the burial-trensit ed by the e à should Completed peen s hes Be 2

The law requires that the death certificate be axecuted signed by ti After this certificata or Attending Physician: funeral n 24 hours efter death.

The Funeral Director: After the further t Hospital completely

Division of Vital Records, P.O. Box 68760,

Certification: Medical

2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)

27. Manner of Death

1 Matural

28a. Date of tnjury (Month, Day Year) 5 Pending Investigation 6 ☐ Could not be

28b. Time of

28c. Injury at Work?

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and manner es stated.

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29b. Signature and title of certifier

1 amc

29c. License number

Hospital

1 Yes 2 No

29d. Date signed (Month, Day, Year)

WiD 30. Name and address of person who completed cause of death (Item 23a) Type, Print XIN SECOUS

lance MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar



**DHMH 16 Rev 6/95** 

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NOV 1 8 1937 James 18 April 19

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death November 17, 1999 DORIS RAUNIO FFII 8:03AM 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Gilchrist Center Towson Baltimore Hours Min. August 21, 1928 9. Birthplace (State or Foreign Country) Connecticutt 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Deys 1 M PAF Months 016-22-4195 Usuel Residence of Decedent 10b. County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 √No Towosn Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2013 Ruxton Road 21204 USA 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 Z Valo If Yes, Give Yeer or Dates: 11 Montal Status Was Decedent of Hispanic Origin? (Specify Yes or No-th Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 Yes XX No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cotlege (1-4or 5+) 5+ Elementery/Secondery (0-12) Mathmetician University 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Waino August Raunio Anna Honkanen 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 2013 Ruxton Road Towson, Maryland 21204 Thomas T Fell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ★ cremetion 3 ☐ Removel from State 11/18/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Cemetery 22. Name end Address of Fecility 21. Senature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home Inc. 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one-cause on each line. 6500 York Road Baltimore, Maryland 21212 Intervet Between Onset end Death Immediate Cause (Final 4 months diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28e. Dete of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier

Division of Vital or Attending Physician: **Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

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Pages 1 and 2 should I nent of Health and Men

Item 27

**Physician** /Medical

Examiner

Physician/Medical Examiner

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Certification:

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24 hours after death.

Funerel Director: A Hospital completaly within 2

**DHMH 16 Rev 6/95** 

certificate

Registrar

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

GBunc 32. Registrer's Signeture NOV 1 8 1999

30. Name and address of person who completed cause of deeth (Item/23a) (Type, Print)

Charles St. Bolto, on I 21204 N. 6/181

no

29c. License number

29d. Date signed (Month, Day, Year) November 17, 1999

**ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician November 16, 1999 1:10 A.M. Olivia C. Fuhrman /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marriott Brighton Gardens of Pikesville Pikesville Baltimore 8. Date of Birth (Month, Day, Year)
Jan. 20, 1916 If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours 1□ M 21 F 83 Director 217-09-5856 Maryland Usual Residence of Decedent with the Manyland 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flame 23s or 28s-f show the Matical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Owings Mills 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 5216 Stone Shop Circle 21117 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. other than "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Physien Important: if item 27 is marked other tha any injury or other traumatic avent, that page. -0-12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 John J. Cronie Annie Rule 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Paul B. Fuhrman - Son 5216 Stone Shop Circle; Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore/Washington Crem. 11/17/99 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. W.EC 8728 Liberty Road Randallstown, MD 21133 23a. Part Enum the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · Arterio cardio vascular Years disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pud Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 | Yes 2 | No 3 | Probably 4 | Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No certificata To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS15 ted 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Living 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital

Medical State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 35844

29d. Date signed (Month, Day, Year) November 16, 1999

Roggen 5400 Old Court Road

Randallstown MD 21133

32. Registrar's Signature 1 8 1999 NOV

parks

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Q Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Christina Rita French 17, Nov. 1999 3:45 A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 505 Granleigh Rd. Owings Mills Baltimore If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 2 TF 80 Months Yrs Director 213-05-2831 Dec. 23, 1918 Baltimore, Md. 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show rount be notified at 1 Yas 2 No Baltimore Maryland Director Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 14. Race - American Indien, Black, Whita, atc. Norma 23a 505 Granleigh Road death Funerai 21117 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) permit. Pagas 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any Injury or other treumatic event, the Health is page. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Office Manager CLeaners 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) William French Carrie Marll 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Catherine Kennedy - niece 505 Gmanleigh Rd. Owings Mills, Md. 21117 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Dete 1 ABurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) New Cathedral Cem. Nov. 20, 1999 Baltimore, Md. 22. Nama and Addrass of Facility
Eckhardt Funeral Chapel 21. Signature of Funaral Sarvice Licensaa to ristan DoceA 11605 Reisterstown Rd. Owings Mills, Md. 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intarvai Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Gnoma WU GLAB Examiner Dua to (or as a consequence of) Examiner physician and the bunal-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events Dua to (or as a consequence of): Box 68760, Physician/Medicai Dua to (or as a consequence of): rasulting in death) Last 88 for usa as datached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t by The law requires 24a. Wes en eutopsy performed? Were autopsy findings available prior to Completed completion of cause of death? page 2 s 1 Yes 2 No 1 Yas 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Aasidence 6 Other (Specify) edicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA Aftar this 27. Mannar of Death To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funera 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 PNatural 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print) 114 Business Kushnb

State Registrar

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Year)

31. Data filed (Month, Day,

**DHMH 16 Rev 6/95** 

32. Registrar's Signatura

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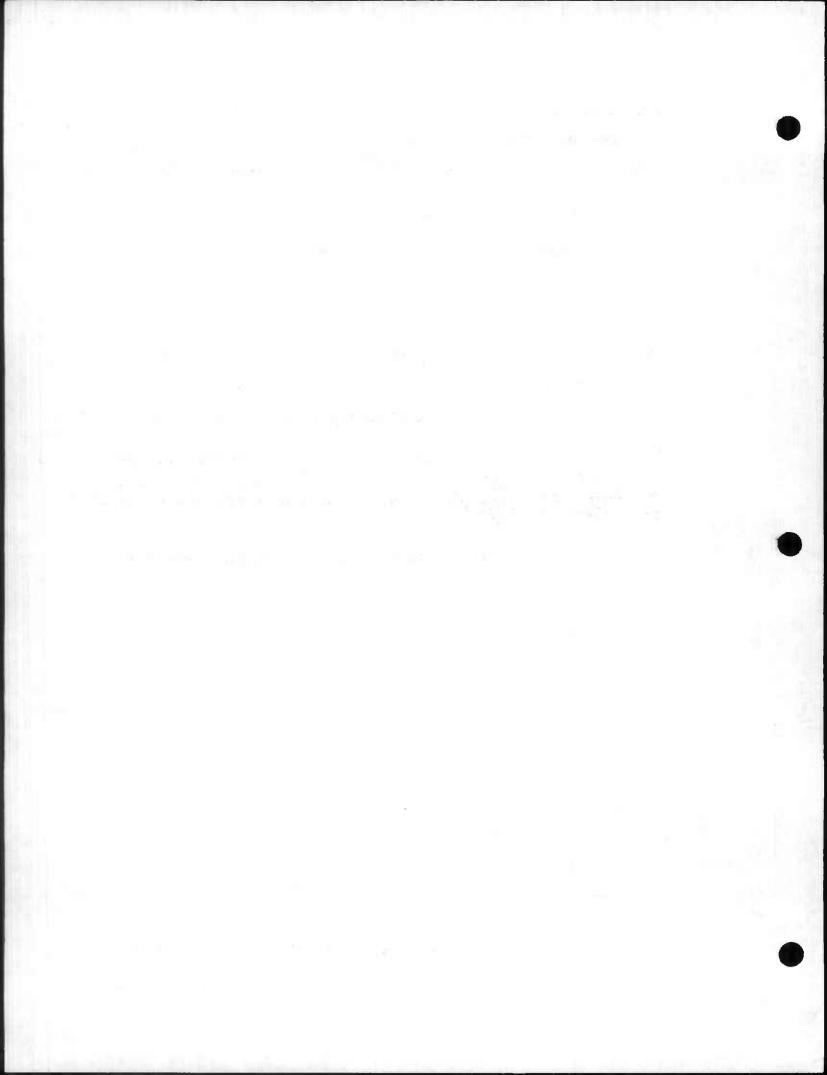
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State of Maryland / Department of Health and Mental Hygiene 99

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Physicia	'n	1. Decedent's Ner	ne (First, Middle	, Last)								2. Dete of De Month		Year	3. Time of Deeth	
/Medic		Margaret K. Foley									November 12, 19			11:30 PM		
Examine	er	4a. Facility Name (If not institution, give street end number) Good Samaritan Hospital									wn, or Lo	cation of Deeth 4c. County of N/		of Deeth		
Funeral Director		5. Social Security 216-03-	4944	6. Sax 1 ☐ M 2 ② XF		89	birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De May	1909	9. Birthp	ece (State or Foreign etry) anada	
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/Medical Examiner pu transit	/Medical Examiner	Immediate Cause disease or conditi- resulting In deeth)  Sequentially list or	on	e. <i>U</i>		Due to (or es	11		Con	mar	ya	rlery	duca	4		
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	Be	25. Wes cese refe	rred to medical							26. Plece	of Deet	h (Check only	one)			
Q 5. Z	0	exeminer? 1 ☐ Yes 2 7	110	Hospital: 1	] Inpatier	nt 2 FER	Outpatien	3 DO	Ot Ot	her: 4 🗆 Nu	ırsing Ho	me 5 Resi	dence 6 □Ot	ner (Specif	y)	
Attending Ph or death. octor: After th by the funeral		27. Manner of Dee 1 ☑ Naturel 2 ☐ Accident	th 5 Pending investiga		e of Injur onth, Day	y Year) 281	b. Time of Injury	M 2	8c. Inju Wo 1	ryet rk? ]Yes 2□		28d. Describe	how injury occu	rred		
i or Attendi efter death I Director: A d in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, of building, etc. (Specify)							, office	ice 28f. Location (Street and Number or Rural Routa Number City or Town, State)					tl Routa Number,	
Hospi 24 hou Funer tely fill	edical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medicel E	Physician: To the	he best of basis of	examination	ige, deeth end/or inv	occurred estigation	et the ti	me, date en opinion, dea	d plece,	end due to the red at the time,	ceuse(s) end m date and pleca,	enner es s end due to	teted. o tha ceuse(s)	
Within 2 To the	Me	29b. Signature end	title of certifiar	,			-	290	c. Licen	se number		T	29d. Date signe	ed (Month,	Dey, Year)	
		> M	Leven	Kurle	ul	···	m		2	2 10 2	2		11-1	5-59		
9		30. Neme end edd	and co	no completed car	811				011	ncla	15	two,	11561 W	201		
Stat Registra		31. Dete filed (Mor	nth, Day, Year)	18 1999		benev.	w	8.	L	parke	2		u1521			



WESTHINSTER HD2115

DHMH-15 Rev 1/89

BALLIMORE, MARTLAND 21203-3146	hin 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	t, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 13140,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First,	Middle, Last)	EL	150	N	GL	ASE	R	2. DATE OF DEATH	1 99	YEAR	3. TIME OF DEATH  9 4 56 Am	
	4. SOCIAL SECURITY NUMB 218-10-8108	1				IF UNDER 1 YE		8888	7. DATE OF BIRTH (Month, Day, Year)		LACE (State or Foreign		
m	9e. FACILITY NAME (If not in:		and number)				MN OR LOCAT		ТН	9c. COUNT		ATH	
DIRECTOR	1334 Denning					New W	indso	5		Carr	<u>oll</u>		
E	10e. STATE	10b. COUNTY	10c. CITY, TOWN O			TOWN OR L	DCATION					10d. INSIDE CITY LIMITS?	
	MD	Carro1	1	1			1 TYES 2 X NO						
FUNERAL	10e. STREET AND NUMBER						10f. ZIP COL			EN OF WH	HAT COUNTRY?		
Ä	1334 Dem						21776			USA			
BY FU	11. MARITAL STATUS  1 Never Merried 2 X  3 Widowed 4 Divo	maou	FORCES? 1 X		MED NO	If ye		an, Mexican,	ORIGIN? (Specify Yea Puerto Rican, etc.)	GIN? (Specify Yes or No— to Rican, etc.)  14. RACE — An Black, White Specify:			
	15. DEC	EDENT'S EDUCATI	ON undertood			JSUAL OCCU		la a	16b. KIND OF BUS	INESS/INDU	STRY	White	
COMPLETED	Elementary/Secondary (0		ollege (1-4 or 5+)	life.	Do NOT use	retired.)	g most of work	ing	Utility				
ON	17. FATHER'S NAME (First, Mi	FATHER'S NAME (First, Middle, Last)  Marketing Manager Utility  16. MOTHER'S NAME (First, Middle, Maiden Sumame)											
BE	Lewis Glase						Ru	ith Mc	Fadden				
0	190. INFORMANT'S NAME (7)								ute Number, City or Tow				
	Marie Glase								Windsor.				
	20e_METHOD OF DISPOSITION  1												
	4 Donetion 5 Dother (Specify) Cedar Lawn  21. SIGNATURE OF FUNERAL SERIES DELEGED LAWN  22. NAME AND ADDRESS OF FACILITY												
	21. SIGNATURE OF FUNERAL 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, P.A.  141 W.Main St. Hancock, MD 21750-0368												
	22 PART I Seter the di	· ·		LOW	<u> </u>								
	23. PART I. Enter the diseases, or complications the caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heert feilure. List only one cause on each line.  Approximate interval Between												
	IMMEDIATE CAUSE (Finel disease or condition peauling in death)										Onset and Death		
	DUE TO (OR AS A CONSEQUENCE OF):											6 mos	
z													
CERTIFICATION	Sequentially list conditions, If eny, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):												
S	CAUSE (Disease or Injury												
E	that initiated eventa resulting in death) LAS	T	DUE TO (OR	AS A CONSE	DUENCE OF	):							
빙	d												
CAL												WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
EDIC	COMP										COMPLETION OF CAUSE OF DEATH?		
Σ	1 U YES 2 1 NO												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)												
S	25. WAS CASE REFERRED TO EXAMINER?	H	OSPITAL:	10.4.4.		OTHER:		1					
Н	1   YES 2 AO   1   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Home 5 (Decidence e   Other (Specify)    27. MANNER OF DEATH   28e. DATE OF INJURY   28b. TIME OF   28c. INJURY AT   28d. DESCRIBE HOW INJURY OCCURED												
	1 Netural 5 Pending (Month, Day, Year) INJURY WORK?  M 1 YES 2 NO												
TED BY	3 Suicide 6	Could not be determined	JURY — At ho (Specify)	ome, farm, s	treet, factory,	office			81. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETE	29e. CERTIFIER (Check only one)  29 IMPROM EXAMPLED On the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and menner se stated.												
00	2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated.												
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	MM				29c LI	Q V		29d. DATE	SIGNED	Moreh, Day, Year)	

2

31. DATE FILEO (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27), (Type,

1999

32. REGISTIAR'S SIGNATURE



**Physician** /Medical Immadiate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediata ceuse. Enter Underlying Cause (Disease or injury Ihel initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 physician Physician/Medical been signed by the attending should be detached for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Completed by this certificate has or Attending Physicien: efter deeth. Director: After this certifice Be 25. Wes case referred to medical 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28e. Date of Injury (Month, Dev Year) 28h. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 TYes 2 □ No Investigation 2 Accident To the Hospital or Atten within 24 hours efter dee To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated.

Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29d. Date signad (Month, Day, Year)

dress of person who pleted cause of deeth (Item 23a) (Type, Print)

Randoh 3333 N. CHLUERT ST HLSS BALT MD 2/218 (A) 31. Dete filed (Month, Day, Year) NOV 1 8

State Registrar

**Physiclan** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

6

Director

Funeral

þ

Completed

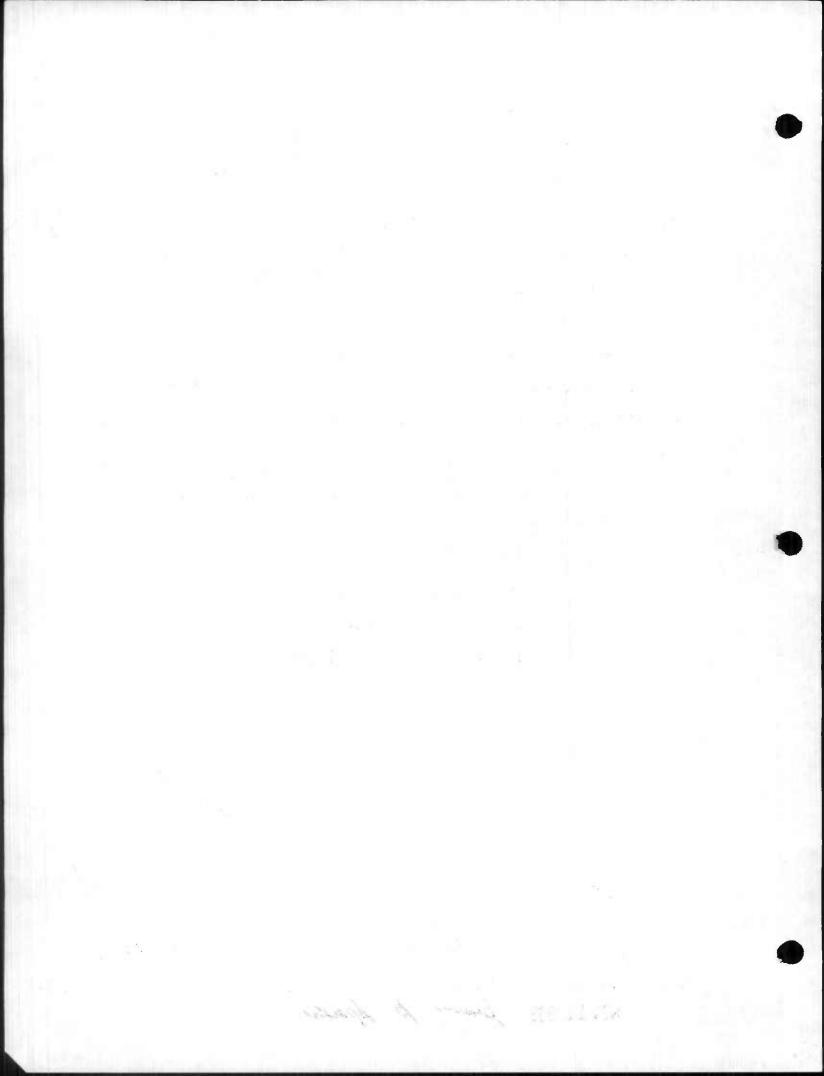
Be

traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Example manages.

Baltimore, Maryland 21215-0020

32. Ragistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 1700 November Mary M. Haney /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Month, Day, May 8, Hospita Agnes 9. Birthplece (State or Foraign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2以 F Yrs. 215-09-0034 83 Director Usual Residence of Decedent with the Meryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Baltimore Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3300 Benson Avenue De Paul House 21227 United States nit. Pages 1 and 2 should be filed within 72 hours efter death variant of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural; or iteme 23s injury or other traumatic event, an Madeal Examination mail Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Reca - American Indian. Bleck, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2N No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working lifta. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8th Homemaker 18 Mother's Name (First Middle Maiden Sumeme) 17. Fether's Name (First, Middla, Last) Holder Carson Jeanette George 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Reletionship (Type, Print) Milton G. Carson/Brother 1410 Scanlan Drive Glen Burnie, Maryland 21061 Baltimore, 20b. Piece of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State Department Important: If 4 ☐ Donetion 5 ☐ Other (Specify) 11/16/99 Loudon Park Cemetery Baltimore, Maryland 22. Name end Address of Fecility
Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee iny 4107 Wilkens Avenue Baltimore, Maryland 21229 lanta J Homas Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, wheart fellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician 60 Hours /Medical immediate Cause (Final disease or condition resulting in death) Jangrenous Examiner Examiner physician end s the burial-trens Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieled events resulting in death) Lest Due to (or es e consequence of) MARYM, HANE Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 98 esn ò signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has 2 M No 1 ☐ Yes 2 No After this cartificate or Attending Physician: funeral diractor. 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Chack only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 1 Naturel 5 Pending after deeth. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homloide 24 hours a 29a. Certifier î Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 900 caton Avenue Battimore, MD 21229

Registrar
DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

NOV18

32. Redistrer's Signature

Mener



THE STATE OF

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36184 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 7:55 pm THOMAS Μ. HIGGINS NOV 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Catonsville Baltimore Center Charlestown Care If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Deys Hours Min. (Month, Dey. Birthplece (State or Foreign Country) NEW YORK 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1⊠M 2□F 169-32-9609 86 Yrs. 01-31-1913 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE CATONSVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 709 MAIDEN CHOICE LANE 21228 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ⊠Yes 2 □ No 1942 − If Yes, Give Year or Dates: 1973 Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3 X Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 DIRECTOR OF TRAINING U.S. POSTAL SERVICE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) JAMES W. HIGGINS MARY Μ. McNAMARA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JAMES W. BROGAN NEPHEW 2703 RAMBLER COURT, ADELPHI, MD 20783 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 11 - 201 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State METRO CREMATORY 4 □ Donetion 5 □ Other (Specify) CATONSVILLE, MD 1999 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Finei disease or condition resulting in deeth) End Itage Congostive Heart failure Year) Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

law requires that the deeth certificate be executed ettending physiclen and for use es the buriel-transit been signed by the e should be deteched Division of Vital Records. efter deeti Director: To the Hospital or Atterwithin 24 hours efter des To the Funeral Director completely filled in by th

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ral', or items 23a or 28a-f show Examiner name be notified at

Pages 1 and 2 should be filed within 72 hours efter death nent of Health end Mental Hyglene.

Whit: If item 27 Is marked other than "natural", or items 23. ury or other traumatic event, the Mexicel Exerciting manal.

Depertment of Important: If it any Injury or o

Physician

/Medical

Examiner

Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

29a, Certifier (Check only one)

29b. Signature end title of certifier

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

with the Maryland

Hospital or Attending Physician:

State Registrar 30. Nemp and address of person with completed cause of death (Item 23e) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year) D51051

November 17, 1999

711 Maiden Choice Lane, Catoniville, MD, 21228 Andres Salazar

12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signeture NOV 18 Deneva

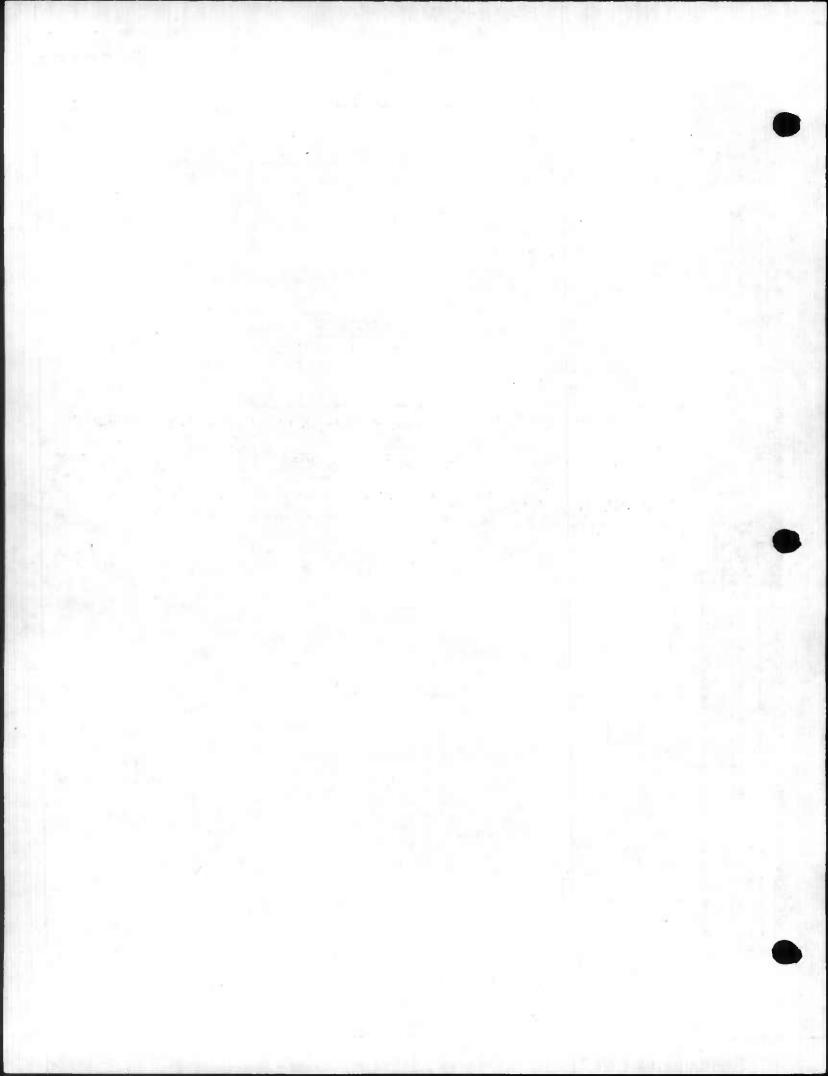
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			Ce	ertificate	e of	Death		Reg. No	、ココ	36	0185	
Dhuninin	1. Decedent's Neme (First, Middle, Las	-					2. Date of I	Death Da	ν ,	Year 3	3. Time of Death	
Physician /Medical	GEORGE ED	WARD H	OHENBER	GER, J			NOV	. 15	$\tilde{5}$ , 1		6:30 PM	
Examiner	4a Fecility Neme (If not institution, give					4b. City, Town,	or Location of De		. County of			
	1311 WHITMAN DR			. Klinder	1 Van	GLEN If Under 24 H	BURNIE			RUNDEI		
Funeral Director	214 30 4433	ex   7. Age (In 59	yrs. last birthday Yrs.	Months	Days	Hours M		9 Birthplace (State or Foreign Month, Dey, Year) 9-30-1940 MARYLAND				
pue Ma	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										Inside City Limits	
with the Maryland a or 28a-f show the notified at	MD. ANNE AR	NE ARUNDEL GLEN BURNIE									1 ☐ Yes 2 No	
uter deem with the Ma r Herma 23a or 28a-f e viner must be notified funeral Director	10e. Street and Number											
by by	11. Marital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S. 13.	Was Deceded If Yes, special 1 Yes 2		(Specify Yes or ! erto Rican, etc.)	No-		14. Race - American Indian, Black, White, etc. Specify: WHITE			
'natural',	15. Decedent's Ed (Specify only highest gra-	ucetion	16a. Dec	edent's Usual	l Occup	eation during most of v	vodkina	16b. K	and of Bus	iness/Indust	iry	
	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	DO NOT use retired) SPATCH / ST		volvang	υ.	S. G	OVERN	MENT	
a other sent, t	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Mail							lle, Maider	iden Sumeme)			
arked out etic ever	GEORGE E. HOHENBERGER, SR. EDNA COLLISON											
To To	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mei	ling Address	(Street	and Number or	Rural Route Nurr	nber, City	or Town, S	tete, Zip Co	de)	
n 27 le	BONNIE LEE HOHENB	ERGER WIF	E 131	1 WHIT	MAN	DRIVE,	GLEN B	URNIE	E, MD	210	61	
permit. Peges 1 and 2 should be filled within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other transity injury or other traumatic event, the Monda.  To Be Comp	20a. Method of Disposition 1   Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Removel from State	Ob. Place of Disp cemetery, cre MEADOWRI	ematory or ot	her plac		Date 11-19 1999			ity or Town, E, MAR		
Depertra Importa any Inju	21. Signature of Funeral Service Licen	Jan A	-			ss of Fecility UNERAL H	OME, INC			LKENS ORE, M		
	Puri1. Enter the disease, or companies, or heart feilure. List only	olications that caused the one cause on eech line.	Do not er	nter the mode	of dyir	ng, such es card	liac or respiratory	errest,		Int	pproximete lerval Between	
nysician Medical xaminer	Immediate Cause (Finel disease or condition		Esoph	rogeal	Ca	vemo	wa			1	set end Death	
ě	resulting in death)		to (or as a conse							- 1	0	
physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate	Sequentially list conditions, if any leading to immediate										
he bui	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
use us	a 'd.											
e ettendi od for use	Part II. Other significant conditions co	entributing to death but not	resulting in the	underlvina ce	ouse div	ren in Part I.	23b. Di	d tobacco	uae cont	ribute to the	e cause of death?	
			1 Yes 2 No 3 Probably 4 Whitnow									
shouli								es en auto rformed?	ppsy	eveilal	eutopsy findings ble prior to letion of cause ath?	
director, pega 2							10	Yes 2	1000	1 🗆 Y	es 2000	
certificeta iractor, per	25. Wes case referred to medical examiner?					26. Place of [	Deeth (Check onl	y one)				
	1 Yes 2000	Hospitet: 1 Inpatient	2 ER/Outpatie				Home 5 Ae	sidence	6 □Other	Other (Specify)		
After funding	27. Manner of Death  1 Deletural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time Injury	of 28	Bc. Injur Wor 1 🔲	y at rk? Yes 2 □ No	28d. Describ	28d. Describe how injury occurred				
within 24 hours after death. To the Funeral Director: After tompletally filled in by the funer Medical Certification:	3 ☐ Suicide 4 ☐ Hornicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
within 24 hours To the Funeral completaly filled Medical Ce	29a. Certifier (Check only one) Certifying Phy one)	raician: To the best of my iner: On the basis of exam and manner stated.	knowledge, dea nination end/or in	th occurred envestigation,	in my o	me, date end pla pinion, deeth o	ce, end due to the	ne cause(s e, date en	) end men d place, er	ner es stete nd due to the	d. e cause(s)	
within To the	29b. Signeture and tille of continer	\		29c.	Licens	e number				(Month, De)	- 40 -	
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1	PETER P. RAMIREZ,		(Item 23a) (Type KWOOD RI		LEN	BURNIE,	MD 21	061				
State	31. Date filed (Month, Day, Year)	32. Redistrar's S	ignature &	lo	onk	21						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 8-10 GLORIA Movember 16, 1999 position of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NONTHWEST GESPITAL BALTIMORE RANDAUS TOWN 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months, Days Hours | Min. (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) Days 1 M 2 F 52 124-40-1539 New York Usuel Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3420 Chapman Road 21133 U.S.A.

14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify. 3 ☑ Widowed 4 Divorced White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) John Canavan Theresa Bowden 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Theresa Anne Bagley 10812 Liberty Road Randallstown, MD 21133 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 11/19 Randallstown, MD Old Holy Family Cem. 21. Signeture of Funeral Service Licensee 22. Neme and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD le ins 21133 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth SEVERAL Immediate Cause (Finel disease or condition resulting in death) SERSUS DAYS Due to (or es e consequence of): SEVENAL DAYS Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Department of Important: If any injury or

**Physician** 

/Medical

Examiner

Directo

Be

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after earl of Health and Mental Hoppiene.

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the Maryland

Examiner physician and the burial-transit Physician/Medical Completed Be Certification: To funeral 27. Mannes of Deeth Hospital or Attanding in 24 hours after death.
He Funeral Director: Aftr pletely filled in by the fur

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

1 Matural

2 Accident

3 ☐ Suicide

29a. Cartifier

Medical

4 Homicide

(Check only one)

29b. Signature end title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. OBSTRUCETIVE pulpoling 25. Wes case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospitel:

28a. Date of tnjury (Month, Day Year)

1 Unpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of Injury

D18502

1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No

Novam Bar 16, 1999

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. tnjury at Work? 28d. Describe how injury occurred 1 TYes 2 □ No

28t. Location (Street end Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

Mrs)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. CONANAN, MD GRUANDO

RANDALISTONN, WY, 21133

State Registrar 31. Date filed (Month, Dey, Year) NOV 1 8 1999

5 Pending investigation

6 Could not be determined

32. Regist/ar's Signature

ooks

NOV 18 184 12 --- 1 James

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death AMENDED #26 PER MD, G777 11/18/99 DH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HEIEN MARRIS NOVEMBER 6 1999 7 AM 1 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Jan, 19, 1999 6 Ivy Lane Anne Arundel 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1 M 200 197-09-8098 PA Director Usuel Residence of Decedent the Meryland 10e State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be nortified at 1 ☐ Yes 2 ☐ No XX Director Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Ivy Lane 21061 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②XXNo If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. filed within 72 hours efter of Hygiene. ther than "natural", or fler 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🌪 ☐ No Specify: Specify: by ₩idowed 4 Divorced White "natursi', Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home permit. Pages 1 and 2 should be filed Department of Health and Mentel Hygi Important: if item 27 is marked other any Injury or other traumatic event, III 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Morris Louis Potts Alice Bourne 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joann Montgomery/daughter 473 London Lane, Severna Park, MD 21146 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Konald S. Wale. Director 22. State Admit Shilly Board 655 W. Baltimore Street 21201 Baltimore, MD ntl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, not, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final ARTERIOSCIGNOTIC CARDIOVASCULAR 5 YEARS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): DISCASA Examiner sicien end buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): physicien s the buriel Box 68760. 99 Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Onknown been signed by should be detac DIABETES Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy DEMENTIA 1 Yes 2 Ho 1 □ Yes 2 □ No Division of Vital Be 25. Wes cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Mannes of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending 1 Yes 2 No deeth. investigation 2 Accident or Attend efter deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral D completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number NOVEMBER 9 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) RITCHIE HWY PASADENA 21122 P. MUNDRA MO 8109 31. Date filed (Month, Dey, Year) Registrar's Signature

Registrar

State

MOV 1 8 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36188 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev Month November Dorothy Agnes Hull 00:10 Am 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deet Hagerstown Was If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) May 25, 1914 Washington Washington County Hospital if Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number Deys 1□M 2▼F Months 85 MD 218-38-1149 Usuel Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 Yes 2 No Washington MD Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21750 13965 Hollow Road USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates: 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Simon Younker Cora Bivens 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Ralph Hull/Son 14019 Hollow Road Hancock, MD 21750 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriai 2 Cremation 3 Removel from State 11/15/99 Hancock, MD 4 ☐ Donetion 5 ☐ Other (Specify) Stone Bridge Brethren 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368
Do not enter the mode of dying, such es cardiac or respirefory errest, 23a. Pert1. Enter the disease, or complice shock, or heert failure. List only one Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) hilt trailer! Cerebo varaly Due to (or es e consequence of): lan- hemipaco Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☐ Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

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/Medical

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**Physician** 

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HULL, DOROTHY AGNES

85 / F

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Physician/Medical þ Completed Be 2 Certification:

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29a. Certifier

(Check only one)

Examiner

or Attending Physician: aftar death. filled in by 24 hours a Hospital complately

within 2. To the F To the

Registrar

29b. Signeture end title of certifier

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29c. License number

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted.

29d. Date signed (Month, Dey, Year)

- CONDIMO

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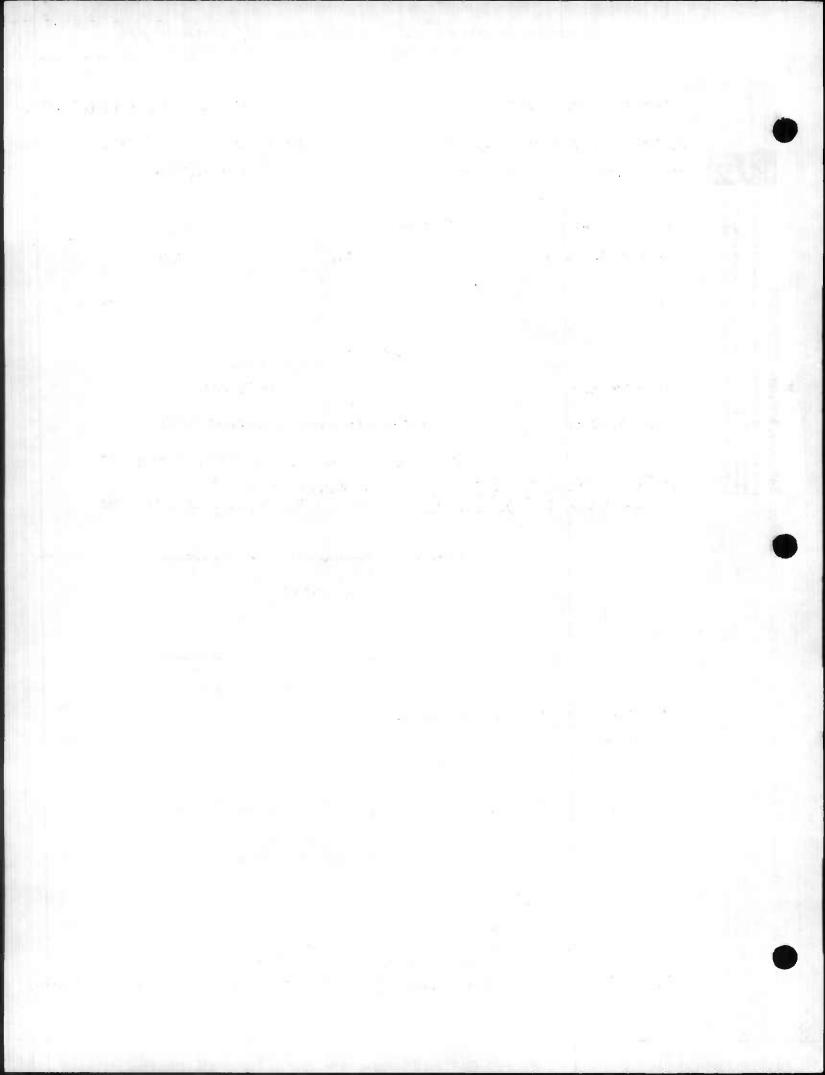
Hagerstown Maryland

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

334 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

Janevas



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State of Maryland / Department of Health and Mental Hygiene 99 36 189

		Certificate of Death	Reg. No.	30103								
		Decedent's Name (First, Middle, Last)	2. Dete of Death	3. Time of Death								
8	Physician /Medical	Michael C. Janceweki	NOVEM HAR OF 1	999 6:15AM								
	Examiner	4h City Town of	r Location of Death 4c. County of	Deeth								
		Stella Maris/Mercy 301 St. Paul Place Baltimo	ore									
	Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) H Under 1 Year If Under 24 Hr.  Months Days Hours Mir	s. 8. Dete of Birth (Month, Day, Year)	Birthplece (Stata or Foreign Country)								
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	ter death with the Maryler terms 23s or 23s-f show the mark to notified at Euneral Director	823 Umbra Street 21224	4 US	SA								
	r hems 23d	11. Meritel Status  12. Wes Decedent Ever In U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- Into Rican, etc.)  14. Rece -	ce - American Indien, eck, White, etc.								
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Maryland 21215-0020	in 72 hours after death with the Manyland Institution is them 23s or 28s-f show solicit Exemination must be notified at	3 Widowed 4 Divorced Year or Detes: 44-46	эреспу.									
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Baltimore,	S 6 = 7	20e. Method of Disposition  1  Buriel 2  Cremetion 3  Removel from Stete	Dete 20c. Location - Ci	ty or Town, Stete								
E	permit. Page Department of Important: If any injury or page.	Donation 5 ☐ Other (Specify)										
a	Semit. Pa Separtmer mportant: iny injury	21. Signature of Funeral Service Licensee Ronald S. Wade, Director State Anatomy B	oard, 655 W. Balt	imore Street								
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	ires that the death ce signed by the attendi d be detached for us d by Physician/	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contr	ibute to the cause of death?								
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of	라는 다	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing	Home 5 Residence 6 Other  28d. Describe how injury occurred									
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	president of the control of the cont											
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Š	A	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  With the state of the s	Builtiney 2120	Z								
	State	31. Dete filed (Month, Dey, Year) 32. Registrers Signeture										
	Registrar	NOV 1 0 1000 6 11 11 11 11 11 11 11 11 11 11 11 11 1										

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 36190 Certificate of Death Amend Item#17.18 perFH G777 11/22/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Rudolph Charles Janda November 16, 11:30PM /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Oak Crest Care Center Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | 8. | Marth Park Year | 1905 5. Sociel Security Number 7. Age (In yrs. last birthday) 94 Yrs. 6. Sex 1 ☐ M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Maryland 216-44-3328 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 715 Maiden Choice Lane 21128 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours effer c Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Mental. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Finance Supervisor United States Postal Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Maria Soukup Unknown-Joseph Janda Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 720 Camberley Circle - B3, Towson, Maryland 21204 Miss. Marie Lang/Friend 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from Stete Druid Ridge Cemetery 11/20/99Pikesville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Funerel Service Licensee Christina L. David Neme end Address of Fecility Leonard J. Ruck, Inc. Day 5305 Harford Road, Baltimore, Maryland 21214 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** 9 days /Medical Immediate Ceuse (Finel noumonia disease or condition resulting In death) Examiner Due to (or es e consequenca of) Examiner attending physicien end for use es the buriel-transit be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequença of) Box 68760, Physician/Medicai Due to (or es e consequence of): P.O. I Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 ☐ Unknown Records, ð Be Completed 24b. Were eutopsy findings evellable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? i certificate hes b 1 Yes 2/2 No 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: T
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 in by the funeral director, pu 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homiclde Hospital of To the Hospital Within 24 hours To the Fyneral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

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30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

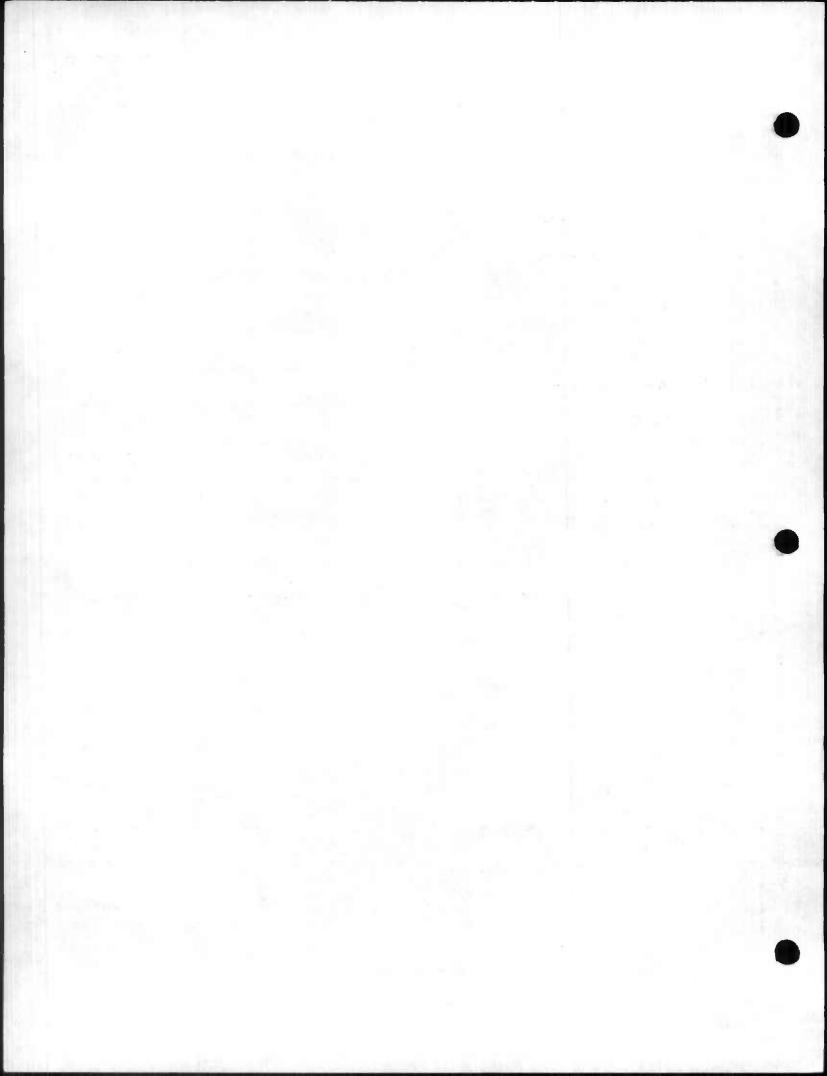
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GERTRUDE KATHERINE KIDD NOV. 16, 1999 10:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4600 REHBAUM AVENUE HALETHORPE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-30-1907 9. Birthplaca (Stete or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Country) MARYLAND 217-38-7674 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified as MD. BALTIMORE 1 Yas 2 No Director HALETHORPE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4600 REHBAUM AVENUE 21227 U.S.A. Funerai 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 7 is marked other traumatic event, to 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 abould be filt timent of Health and Mental H tant: If Hem 27 is marked oth jury or other traumatic even FRANK B . WOODEN LAURA I. MYERS 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KENNETH W. KIDD SON 4600 REHBAUM AVE., BALTIMORE, MD 20b. Plece of Disposition (Name of cametery, cremetory or other p 20a. Method of Disposition 11-20 20c. Location - City or Town, Stete or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: If any injury or page. DRUID RIDGE CEMETERY 1999 PIKESVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD N -Allann 10 21229 23a. Part / Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, sheek, or heart failure. List only one cause on each line. Approximete Intervat Between Onset end Death Physician /Medical Immediate Cause (Final · Acute my ocard disease or condition resulting in death) Examiner oulerote the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, la Physician/Medical 20 080 signed by the at I be detached for Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? funeral director, page 2 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No certificata or Attending Physicien: 25. Wes case referred to medicat 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Mannge of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? Division After 1 Naturat 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) filled in by 4 Homicide hours a 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and menner steted. one) To the I ature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Sign Nov. 18, 1999 aurence (Gallagas, M) D017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAURENCE GALLAGER MD 716 MAIDEN CHOICE LANE, BALTIMORE, MD 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

26

DHMH 16 Rev 6/95

Registrar

NOV 18



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED #23a PER MD, G777 11/18/99 DH/dhb Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death October 28/1999 12:30 Pm Anna Kline 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (# not institution, give street and numbar) Samaritan nospital Baltimore City BAltimore 000 If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) Birthpleca (Stete or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Months Days Hours Min 1 MX & F Yrs. Mary Tand 90 16,1909 218-50-7180 Usual Residence of Decedent 10a. Stata 10h Counts 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore County 1 ☐ Yes 2x No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8903 Mavis Avenue 21236 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes ZNO SpecifyWhite Spacify: 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade com completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaking-Own Home N/A 5th grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Peter A. Comes Anna Tremper 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia A. Parkhurst 19719 Gunpowder Rd. Millers, Md. 21102 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Joseph Church Cemetery 1030-99 Fullerton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility E. F. Lassahn Funeral Home 21. Signature of Funeral Service Lice 11750 Belair Rd. Kingsville, Md. 21087 or the diagram, or complication. In a caused the death. Do not anter the mode of dying, such as cardiac or raspiratory errest, heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Cardiorespiratory arrest Immediate Cause (Final diseese or condition resulting in deeth) 15 minutes Due to (or as a consequence of) 15 days ARDS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): SEPSIS 15 days Dua to (or as a consaquance of): LUNG CANCER years 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Menial Hygiane. Important: If Item 27 is merked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Wedfel Examiner must be northed.

Saltimore, Maryland 21215-0020

Examiner physician and the buriel-trensit Physician/Medical USB BS attending f ed by the a signed by t by been si Completed s certificate has b director, Be Certification: To this funeral Affer thin 24 hours efter death, the Funeral Director: Af mpletely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

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Pert If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cese referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

 Location (Street end Number or Rural Routa Number, City or Town, Stete) Dertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the ceuse(s) and mannar es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person no completed ceuse of death (Item 23a) (Type, Print)

och Raven Blvd. 21239 31. Date filed (Month, Dav. Year)

State Registrar

Medical

29e. Certifier

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30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar

54 11-WD-

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Edythe M. McCleary 9:40 PM NOVEMBER 17, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1□M 2ŪF Months 96 218-07-6687 MAY 30, 1903 Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits **ehow** 1 ☐ Yes 2 No Baltimore Towson Director MD 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21204 IISA 7001 N. Charles Street "natural", or items 23a Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Merital Hygiene Important: if from 27 is marked other that eny fullury or other treumatic event, that page. Own Home 10 Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Sadie Unk. Mark Santmyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18330 Augusta Dr. Monument. CO 80132 19a. Informant's Neme/Relationship (Type, Print) 18330 Augusta Dr. Monument, CO George McCleary/son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Metro Crematory, Inc. 11/18/99 Baltimore, MD 4 Donetion 21. Signature of Puperal Service Licensee,

Edward A. Gregorchik 22. Name and Address of Eacility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be execu P.O. Box 68760. Physician/Medical Due to (or as a consequence of) signed by the a d be detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. þ or Attending Physicien: The lew requires Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 1 ☐ Yes 2 ☐ No certificate funeral director, Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No 1 Inpatient this Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours efter deeth.

Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier compietaly (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier, 2-12849

State Registrar

**DHMH 16 Rev 6/95** 

OSLEK Dr. TOWSON. Md 21204

30. Name end eddress of person who completed cause of death (ttem 23a) (Type, Print)

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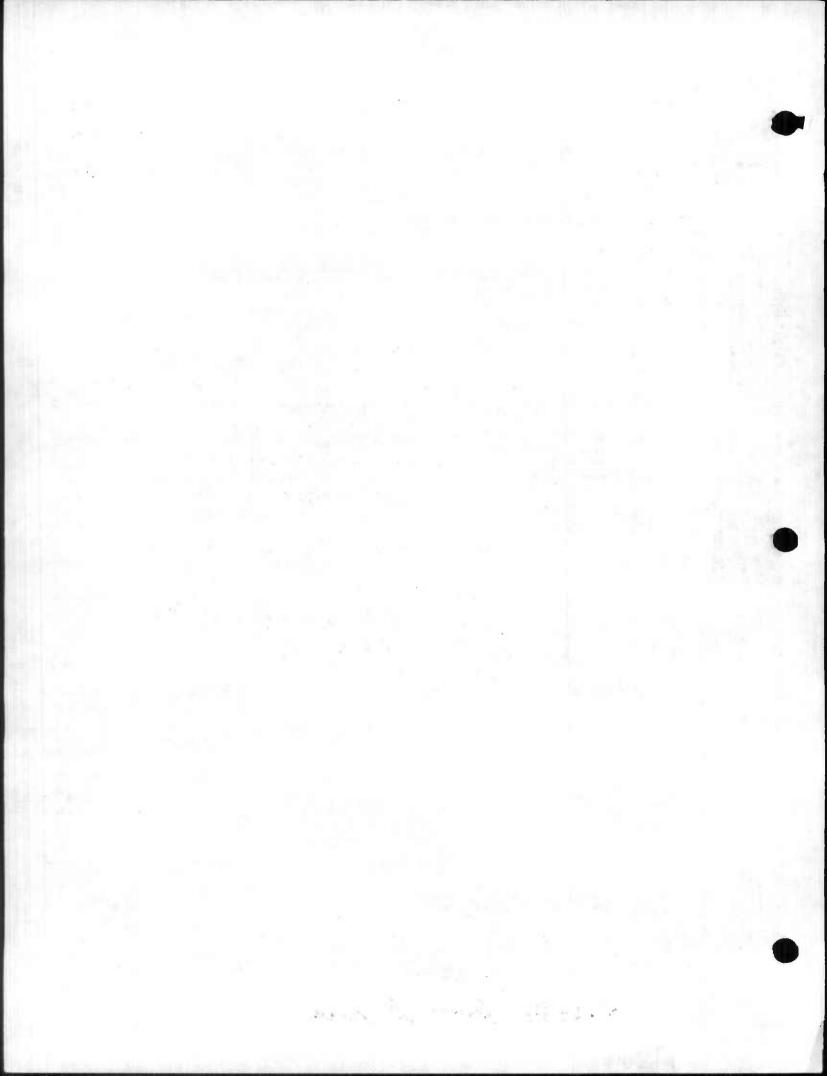
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- BYWELL

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician MYRTLE MOORE NOVEMBER 14, 1999 6:30 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1504 SAPPINGTON DRIVE GAMBRILLS ANNE ARUNDEL If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 💢 F Hours APRIL 17,1932 PENNSYLVANIA 219-28-1778 Director 67 Usual Residence of Deceden the Meryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 1 ☐ Yes 2 X No Director MARYLAND ANNE ARUNDEL MILLERSVILLE 10e Street and Number 101. Zip Code 10g. Citizen of Whel Country? 470 SKI LANE 21108 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces' Bleck, White, etc. filed within 72 hours after Hygiene. Hygiene. "netural", or ite 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. ð WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Heelth and Mental Hyglen. Important: if item 27 is marked other tha eny Injury or other treatmetic event, that one HOUSEKEEPER HOSPITAL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Sumeme) 8 HARRY W. HENDERSHOT FLORENCE PITTMAN 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GARY MOORE- SON 1504 SAPPINGTON DRIVE, GAMBRILLS, MD 21054 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 11/19/99 GLEN BURNIE, MD 21. Signature of Funeral Service Coerts 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician M. tastatic (arcin and /Medical Immediala Causa (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examine a n creas physician and s the burial-transit be assouted he one chish ctive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Box 68760 Physician/Medical 980 P.O. | 23b. Did tobacco ase contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 4 1 1 X68 2 No 3 Probably 4 Unknown bengis Records. by 24b. Were eutopsy findings aveilable prior to completion of causa of deeth? 24a. Wes an autopsy performed? Completed peen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: director. 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Con's Hospital: Other: 4 Nursing Home 5 Rasidence 6 Detner (Specify) Home 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Aftar thi 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ENatural To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 - Online Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. Medicai 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steled. (Check only one) 29c. License number 29b. Signeture and title of certified 29d. Date signed (Month, Day, Year) WI 6 /e 1 /30 UNIC MY 30. Name end address of person who comp ed cause of death (Item 23a) (Type, Print) 20 ac 31. Date filed (Month, 32. Registrer's Signetura State 8 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item#32 perDVR G777 11/18 State of Maryland / Department of Health and Mental Hygiene 3619 Amended Item#26 perPHYG777 11/18/99 EW Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death **Examiner** altimor If Under 24 Hrs. H Under 1 Year 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Days 10 M 20 F Months Yrs. 710 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 12 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Funeral Wes Decedent Ever in U,S. Armed Forces?

1 Dayes 2 No H Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 wth 17 Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 19a. fnformant's Neme/Reletjonship (Type, Print) Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cornetery, crematory or other) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion ☐ Other (Specify) 21. Signeture Abuneral Service License P2 Name and Addre 10m 1229 treanilton Pus e, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acres disease or condition resulting in death) Examiner sease Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thef initiated events resulting in death) Last Due to (dr es e consequence of) Physician/Medical Due to (or es a consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pertension Àq Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOA DO 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient-28a. Dete of injury (Month, Day Year) Certification: 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Li Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760,

**Funeral** 

Director

death with the Maryland

permit. Peges 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or itema 23a or 28a-f show any highry or other traumatic event, the tender at Evantiner must be indiffed in Defice.

**Physician** /Medical

Examiner

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been signed by the ettending post-should be datached for use as

has pege 2

certificate

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After

death.

within 24 hours after deat To the Funeral Director:

filled in by the funeral director,

complately

(Check only one)

Kichard

29b. Signature and title of certified

31. Dete filed (Month, Dey, Year)

address of person who completed cause of death (Item 23a) (Type, Print) 4660

or Attending Physician:

To the Hospital

altimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

State

Registrar

32. Registrar's Signature

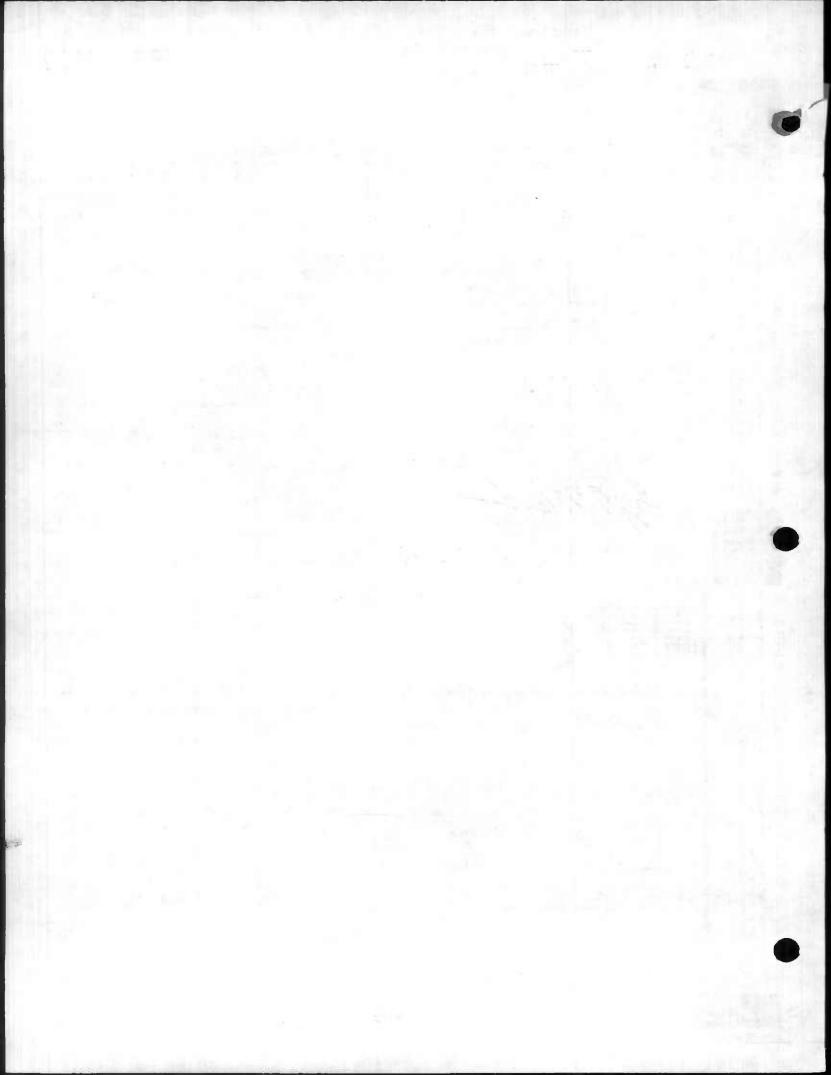
29c. License number

3866

Maryland

29d. Date signed (Month, Day, Year)

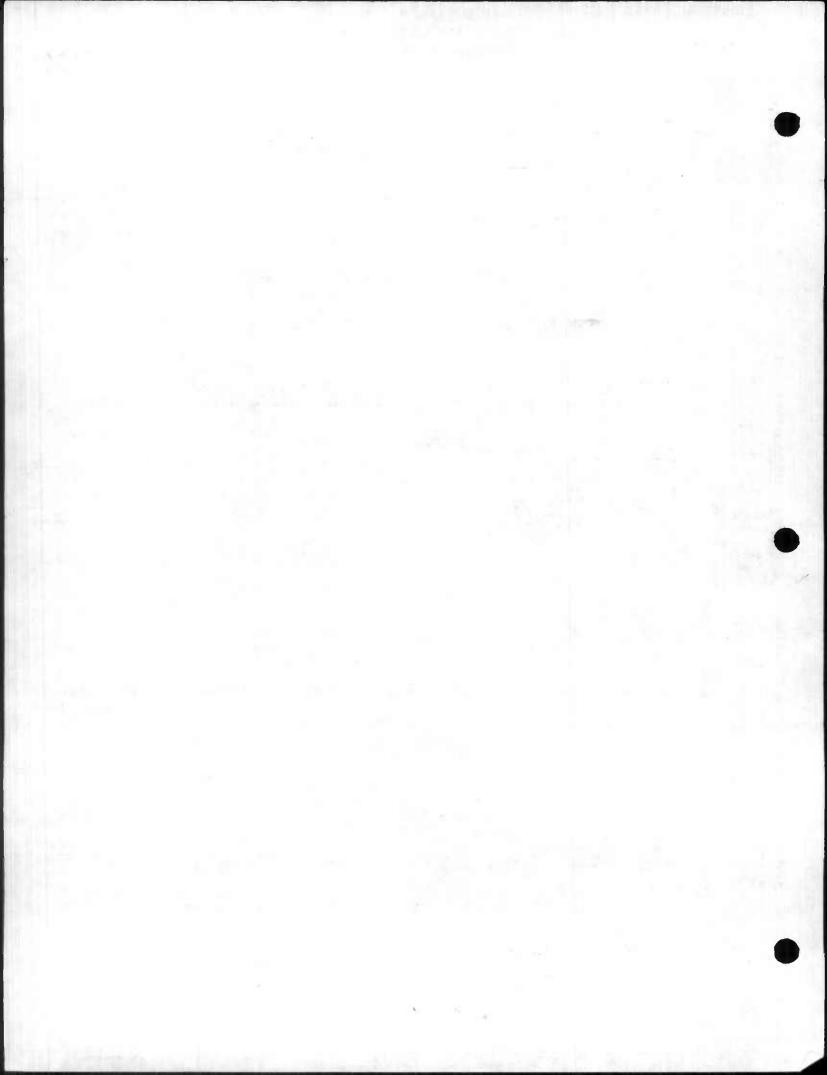
**ORIGINAL** 



99-6796-003 Amend Item#6 perFHG791 1/22/2001 EW DDG Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. KHAYLAN MONTROSE State of Maryland / Department of Health and Mental Hygiene 99, 27 PER MEO Certificate of Death WR. AMEND ITEMS: #23 PART I, 27 PER MEO 1. Decedent'a Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** KHAYLAN R. MONTROSE NOVEMBER 13, 1999 0142 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL ANNE ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 21 1K) M 200 F Months 218-55-7340 Director August 25 1999 Maryland Usual Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits wow r than "natural", or items 23s or 28s-f shorthe Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 139 Faywood Drive, Apt. E. 21060 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Heelth and Mental Hygiene. Important: If frem 27 is marked other than "natural", or frem eny injury or other traumatic event, the Hedges Franch Black, White, etc. 1 Yes 2 No Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White A 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cottege (1-4or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be R. Gordon Montrose Marcia Beaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon R. Montrose (father) 139 Faywood Drive, Apt E. Glen Burnie, MD. 21060 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/18 Greenwood Cemetery Brooklyn, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Stallings Funeral Home, P.A. 21. Signature of Funeral Se 3111 Mountain Road, Pasadena, MD. 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting In deeth) MYOCARDITIS /Medical Examiner Due to (or es a consequence of) Examiner i or Attending Physicien: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the ettending physicien end the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Les! Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): signed by the ettending p d be detached for use es 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? page 2 ZE Yes 2 □ No Maryes 2□ No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To YSYes 2□ No 2√2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. NOVEMBER 14, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Denni 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State NOV 18 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month NOV Day **Physician** Daniel Nathans 16, 1999 9:00 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2227 Crest Road Baltimore N/AIf Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 1₩ 2□ F Months 222-16-7692 Director OCT 30, 1928 Delaware Usual Rasidence of Decedant 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at Director MD N/A 1 Tyas 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2227 Crest Road 21209 USA death v Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after Hygiene. Wher than "natural", or its 1 ☐ Yas 2 No 1 Nevar Married 2 Married altimore, Maryland 21215-0020 If Yas, Giva Year or Dates: 1 Yas 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Depertment of Health end Mental Hygiens important: If frem 27 is marked other true any filury or other traumatic event, the bhose. Microbiologist Medical School 5+ 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be Samuel Nathans Sarah Levitan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2227 Crest Road Joanne G. Nathans/Wife Baltimore, MD 21209 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 11/17/99 Baltimore, 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Edward A. Gregorchik Cremation Society of MD 299 Frederick Road Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Edward A. Cremation Society of MD, Inc. Baltimore, MD 21228 Approximata Intarval Batween Onset and Daath ,Physician /Medical Immediata Causa (Final WSMANT disaasa or condition rasulting in death) Examiner Examiner sicien and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last physicien as the burial Box 68760. Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. been signed by the a should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Ware autopsy findings availabla prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No certificate 1 Yas 2 No Division of Vitai or Attending Physician: funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 □Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Matural 28a. Data of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending deeth. 1 ☐ Yas 2 ☐ No invastigation 2 Accident 24 hours after deet 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the \$ £ 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 12004218 30. Nama and addrass of pr completed causa of death (Item 23a) (Type, Print) Cale - 600 W Wolfe St. 10/19248 31. Data filed (Month, Day, Year) 32. Registrar's State Registrar

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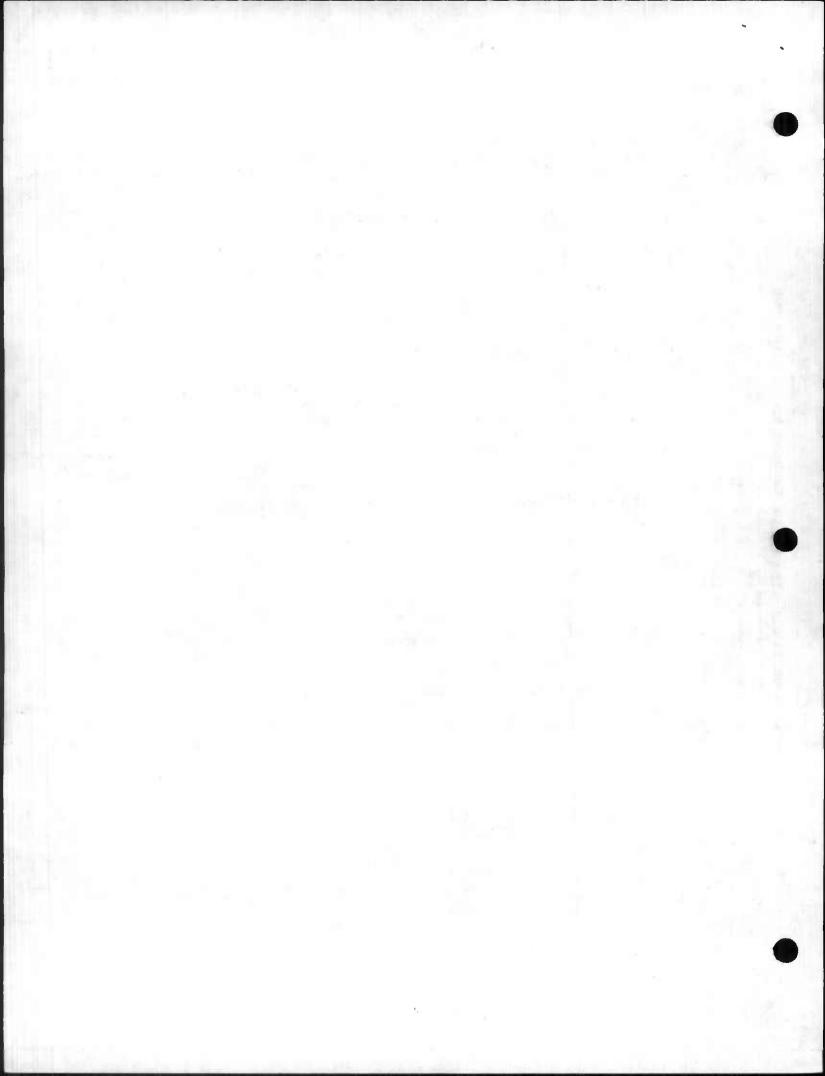
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month Year **Physician** JOHN JAMES O'DONNELL 15, 1999 10:10AM NOVEMBER /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 15 M 2□ F Yrs. 231-16-6288 Director 86 Sept 29, 1913 Maryland Usual Rasidanca of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yas 2 No Baltimore County Towson Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 803 Quincy Road death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after. Depertment of Health and Mentel Hygiene. Important: If Nem 27 is marked other than "natural", or Net any Injury or other treumatic event, the Medical Examinations. 1 Nevar Married 2 Married 1⊠Yas 2□No If Yas, Giva WW2 altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Golf Course Golfing Pro 8\_th 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Brady Nan 2 Francis Joseph O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 803 Quincy Road, Baltimore, Maryland 21286 Mrs. Michelle A. O'Donnell (Wife) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Dafa 1 以 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MD Veterans Garrison
22. Name and Addrass of Facility 11/19/99 Garrison, Maryland 21. Signature of Funaral Saprios Hoensee

Martin D. Lawson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximately 1. Inches 1. Inches 1. Inches 2. Inche Approximete Intarval Between Onset and Death Physician /Medical Immediata Causa (Final CONGESTIVE HEART FAILURE DUE TO 1 YEAR disaasa or condition rasulting in daath) Examiner Due to (or es e consequence of) Examiner CORONARY ARTERY DISEASE YEARS physician end the burial-transit the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consaguança of) Box 68760 Physician/Medical Dua fo (or as a consequanca of) 89 esn Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE þ Records. requires 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? DIABETES MELLITUS certificate has b The lew 1 Yas 2 No 1 ☐ Yas 2 No Division of Vital Attending Physician: Be 25. Was casa refarred to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred After 1 Natural
2 Accident 5 Panding ne Hospital or Attending n 24 hours after deeth. The Funeral Director: After pletely filled in by the fun 1 ☐ Yas 2 ☐ No invastigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homloida 1 XXertifying Physician: To tha best of my knowledge, death occurred et the time, date end place, end due to tha causa(s) and mannar as stated. edicai 29a. Cartifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the fime, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signatura and fitle of certifiar 29c. License number 19508 I, de Leon, mid alwaded 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) NATIVIDAD D. DELEON M.D. 7601 OSLER DRIVE, TOWSON MARYLAND 21204 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State NOV 1 8 1999 Registrar

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			Certific	ate of Death	Reg.	. No.	36201
Physician /Medical Examiner	4e Fecility Neme (If not institution,	EVER EHE		4b. City, Town, or I	2. Dete of Death Month  No.U.  coation of Death	Day Yea 9 /99 4c. County of De	9 10:151
Examiner	809 N. HOI	NOE Street	4	Balti.		0/	<b>b</b>
Funeral Director	5. Sociel Security Number  2/2-24-9/62  Usuel Residence of Decedent	Sex 7. Age (In yrs. 72	Yrs. If Un	der 1 Year If Under 24 Hrs. ns Days Hours Min.	8. Date of Birth Month, Day, Y	ear) 9.8	inthplace (State or Foreign Country) Mary form
New Market	10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show must be notified at	May/mb /	/A	BA/AM	Zip Code	140	000 -1000 11	1 des 2 □ No
iner death with the Mark tems 23s or 28s-1s. Information pointing.	808 N. HON	STOE STREET		21217	109	Citizen of What (	Country
ors afford and a series of the	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 12 Yes 2 No / 9 If Yes, Give Year or Dates: / 9	30-	cedent of Hispanic Origin? (S. pecify Cuban, Mexican, Puert 2 No Specify:	pecify Yes or No- o Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
"netural", ofca Exp	15. Decedent's		16a. Decedent's U			b. Kind of Busines	ss/Industry
and Mental Hygiene.  In Market Other than "natural reumatic event, tre Medical  To Be Completed	(Specify only highest (Specify only highest	College (1-4or 5+)	MECH,		J.	moco	service n
ent, o	17. Father's Neme (First, Middle, La			18. Mother's Nen	ne (First, Middle, Ma		
marked o	RUBERT			Mar	the Ory	toro	
N Due	19a. Informant's Name/Reletionship	(Type, Print)		ess (Street and Number or Ru			
Health em 27	Edith Oxfo	9 /		MONTOE STYE			Med 21217
1 20 2	20e. Method of Disposition  12 Buriel 2 Cremation 3  4 Donetion 5 Other (Spe	□Removel from State		est //Elevors Ca	meters 99	C. Location - City of	mills, he
Department important: I eny Injury once.	21. Signeture of Funerel Service Lie	profes alris	534	and Address of Facility Co DRASTERSTE	JATHA BA	- Waver	is A. H.
	23a. Pert1. Enter the disease, or co shock heert feilure. List on	mplications that caused the death			or respiretory errest	,	Approximete Interval Between
nysician Medical xaminer	Immediate Ceuse (Final diseese or condition resulting in deeth)		0	state Can			Onset end Death  4 44 -
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g physician end as the burial-transit edical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (o	r es e consequence	of):			
0.6		C Due to (or	r es a consequence o	or):			
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by the stached	Pert II. Other significant conditions	contributing to death but not resu	ulting in the underlyin	g cause given in Pert t.	23b. Did tobe		rie to the cause of death' Probably 4 Unknow
signed to be de d by f					24a. Wes an a	urtoney 24	b. Were eutopsy findings
as been 2 shou					performe		available prior to completion of cause of death?
page Con					1 ☐ Yes	213 No	1 ☐ Yes 2 ☐ No
ctor,	25. Was case referred to medical examiner?				th (Check only one)		
tar this conneral direction. To	1 Yes 2 No  27. Menner Deeth 1 Netural 5 Pending	Hospitel: 1 Inpatient 2 Inpati	ER/Outpatient 3 28b. Time of Injury	DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how		pecify)
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.  Medical Certification: To Be Completed by Physician/M	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be de Blees of Injury At he	M ome, ferm, street, fac y)	1 Yes 2 No	28f. Location (Stree City or Town, S		Rural Route Number,
4 hours Funerel tely filled Ical Co	29a. Certifier 1 Certifying I	Physician: To the best of my known in the basis of examinet	wledge, death occurr	ed et the time, date and place ion, in my opinion, deeth occu	, end due to the caus rred et the time, date	se(s) and manner and plece, and d	as stated. lue to the cause(s)
thin 2 mplet	one) 29b. Signeture and title of certifier	and menner steted.		29c. License number		Date signed (Mo	
¥ 6 8	296. Signeture and title of certifier	wing		D 26 25 6		ululula	
3	30. Name and address of person who		1 23a) (Type, Print)	BUD BA	LTIMORE	MD	2/230
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Signa	turo /	racks			
Registrar	NOV 1 8 19	199	N. 14	10cms			



State of Maryland / Department of Health and Mental Hygiene 36202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 1999 Daniel Ray Pippin NOV 15, 9:10 PM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Cromwell Genesis Eldercare Baltimore Baltimore 9. Birthplaca (Stete or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Dey, Year), MAY 9, 1942 **Funeral** M 2DF Months Deys Hours 233-62-6772 57 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits **ehow** r than "natural", or Rema 23s or 28s-f ehov the Redical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3506 Wheelhouse Road 21220 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 1 0 6 0 14. Race - American Indien, Armed Forces? 1960/ 1 1 Yes 2 No 1960/ If Yes, Give Year or Dates: 1966 Bleck, White, etc. 72 hours efter 1 Never Married 2 Married 1 Yes 2 No Specify: Baitimore, Maryland 21215-0020 Specify: P White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Depertment of Health and Mental Hyglene. Importants if Item 27 is marked other than "nat, any Injury or other treumatic event, the Medical abids. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aviation Machinist Aerospace 12 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumame Be 0 Walter E. Pippin Nora Hobbs 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Anette J. Pippin/wife 3506 Wheelhouse Rd. Baltimore, MD21220 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/17/99 Baltimore, MD 21. Signature of Funeral Service License 22. Name end Address of Facility Cremation Society of Maryland, Inc. wechih Edward A Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician 2 montro UNG CANCER Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Examiner physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be datech 1 Yes 2 No 3 Probably 4 Unknown Records. þ should ! Completed 24b. Were autopsy findings evailable prior to 24a. Was an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Mospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica compliately filled in by the funeral director; p. 25. Was case referred to medical 8 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4™ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D52279 4920 Campbell BUD My 21239 30. Name and address of person who completed cause of death (flow 23a) (Type, Print) BALASUBRAMANIAN RIRAM

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signature

whole is arrived in a sound

36203 State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:03 pm LINTON NOV BENJAMIN PUMPHREY /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BUENIE ARUNDEL HOSPITAL NORTH GIEN AACOUNT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months 10XM 2□ F Deys Hours SEPT. 10, Director 80 1919 MARYLAND 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No Director MARYLAND ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 21146 U.S.A. Name 23a Funeral 41 McKINSEY ROAD APARTMENT 119 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien Bleck, Whita, etc. 1 Never Married XX Merried 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specity: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene SUPERVISOR TAXES 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be I nent of Health and Mental I LINTON **ABRAHAM** PUMPHREY **EMMA** W. REINECKE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MS. BETTY PUMPHREY (DAUGHTER) 8104 FOXBERRY LANE, APT. 1418, PASADENA, MD. 21122 Nem 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removet from Stata 4 Donation 5 Other (Specify) GLEN HAVEN MEMORIAL PARK 11/17/99 GLEN BURNIE, MD. 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 kall 23a. Part1. Enter the disease, or complications that dust the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause or each ties. Approximata nterval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 60MIN Examiner HOO N Physician/Medical Examiner YUCMIAZ INFMEMON sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ng physician : as the burial 10 YAS. Conuntry MIRSTY D15474867 Due to (or es e consequence of): USB 23b. Did tobacco use contributa to the causa of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 20 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy tindings availabla prior to completion of causa of deeth? Completed 24a. Was en eutopsy performed? page 2 certificate has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funaral director. 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Netural 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certified 16/99 Blever DO 1861 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S GYGRIVA PIMK 8 PRENGUESEN win MD 21146 CHUNCH EM MO 31. Date tited (Month, Pay 32. Registalir's Signature

**DHMH 16 Rev 6/95** 

State Registrar

Baltimore,

The law requires that the death certificate be assecuted

Box 68760.

P.O.

Division of Vitai Records,

or Attending Physician:

40V 181993 Summer & Sometar

State of Maryland / Department of Health and Mental Hygiene Q Q 36204 AMENDED #1, PER MD, G777 11/18/99 DH Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death James Matthew Petersen Month Physician - WATTHEW 1926 CIERSE OCTOBER 1999 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth John Hopkins Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Funeral Days 17 1⊠M 2□ F Months Hours Feb. 10, Virginia Director 229-83-7382 8 **Usual Residence of Decedent** the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2 No Director Prince William than "natural", or hams 23s or 28s-f Va. Manassas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? A IT 7303 Mariposa Drive 20112 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. a filed within 72 hours effer il Hygiena. other than "natural", or ha 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygle. Important: if Item 27 is marked other tt any lolury or other traumate event, the page. 0 None None Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Annette M. McCallum Mark O. Petersen 19a. Informant's Name/Relationship (Type, Print) (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7303 Mariposa Drive, Manassas, Virginia 20112 Mark & Annette Petersen altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 30, 1999 Manassas, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Stonewall Memory Gardens 21. Signature of Funeral Service Licen 22. Name and Addrass of Facility Price Funeral Home, Inc. 9609 Center Street, Manassas, Virginia 20110 23a. Part1. Enter the disease, or conshock, or heart failure. List why lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximete Intarval Batween Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) edema one day pulmonary Examiner Due to (or es a consequence of): Examiner congestive heart ailure The lew requires that the death certificate be assouted physicien end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. congenital heart disease eight months Physician/Medical Due to (or es a consequence of) 100 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.0. à 1 Yes 2 No 3 Probably 4 Unknown be der of Vital Records. by 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy certificate has 1 Yes 2 No 1 ☐ Yes 2 2 No Attending Physician: director. 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation Division ie Hoaptal or Attenuirs in 24 hours after death. The Funerel Director: Aft 1. Naturat 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At homa, ferm, street, lectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatury and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) with control MD. RES-000 OCTOBER 27, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JEANETTE.

31. Date filed (Month, Day, Year) NOV 1 8 1999

R. WHITE

MD 32. Registrar's Signature

600 NORTH WOLFE STREET, BALTIMORE MARYLAND 21287

from to from

NOV 1 8 1999

Please Type or Print in Black indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dev **Physician** 1999 Nov. 16, 6:30 AM Milton L. Quick /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St. Elizabeth Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 20 F Months 1916 Maryland Director 212-05-8949 83 15, Aug. Usual Residence of Decedent Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Wedical Examiner must be notified at 1 ▼Yes 2 No Director Baltimore Maryland n/a permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23s or 28s-2010s. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 919 Rockhill Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 N Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: P White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Insurance 12 Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jenny Leonard Charles Ouick 19b. Maiting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 5823 Jasmine Circle, E. Syracuse, New York 13057 Judy A. Corigliano / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burlal 2 □ Cremation 3 □ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Ceme. 11/19 Crownsville, Maryland 22. Nama and Address of Fecility
Hubbard Funeral Home, Inc. neral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical tmmediate Cause (Final metastatic Peostate accinoma disease or condition resulting in death) Examiner Examiner physicien and the burial-transit The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. **Physician/Medicai** Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has t 2 X No 1 Yes 1 Yas 2 No Division of Vital or Attanding Physician: attar deeth. Director: After this certifica director, Be 25. Was casa referred to medicat examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or A within 24 hours aftar To the Funeral Directompletely filled in by Descritifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one)

**DHMH 16 Rev 6/95** 

State

Registrar

29b. Signeture end title of certifier

30. Name and addrass of person

31. Date filed (Month, Day, Year)

Tyotin

NOV 18

as

1999

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

821

Mis

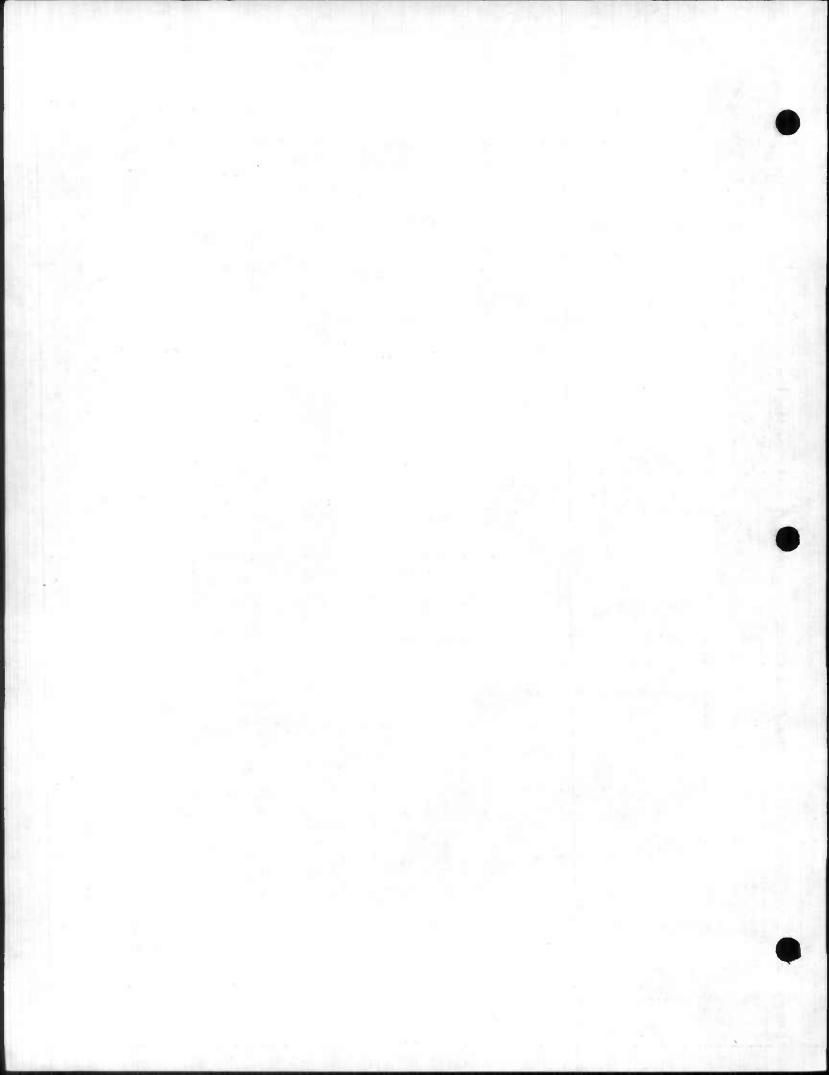
29c. License number

D32158

29d. Date signed (Month, Day, Year)

11/18/99

N. Entaw St Juite 407, Baltimore MD 21201



State of Maryland / Department of Health and Mental Hygieneg 9

36206

	Certificate of Death	Reg. N		0200
Dhuaisian	Decedent's Nama (First, Middle, Last)	2. Data of Death Month	ev Year	3. Time of Death
Physician /Medical	Mary R. Rice	NOVEMBER	12 1999	7:10 AM
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Li	ocation of Death	Ic. County of Death	1
4	NORTH HRUNDEL HOSTITAL GLEN DU	PNIE L	NNE HR	UNDEL
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  North Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	nplece (Stete or Foreign untry)
Director	Usuel Residence of Decedent	July 15,	1918 New	York
death with the Maryland rms 23s or 28s-f show rms to notified at neral Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
4 show	Maryland Anne Arundel Severn			1 ☐ Yas 2 No
be notified Director	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cor	untry?
23a or	1355 Severn Road 21144	US	3.4	
or hame 23e or 28e-f ahor miner must be notified at Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
or hams miner m	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Bleck, White	e, etc.
9	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Wh	ite
d other than "natural", avent, the Medical Ex- avent, the Medical Ex- Be Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of work	16b.	Kind of Business/I	ndustry
upie	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  (Give kind of work done during most of work life. DO NOT use retired)			
CO	Unknown Home maker		vn home	
Be very		e (First, Middle, Maide	an Sumame)	
ام و ا	Frederick Nauman Marie U	nknown		
E al	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rur			ip Code)
her t	Robert E. Rice, Jr. / Husband 1355 Severn Road, Sever	1		
or of	20a. Method of Disposition  20b. Place of Disposition (Name of cernetery, cremetory or other place)  20c. Method of Disposition (Name of cernetery, cremetory or other place)		Location - City or 1	
luny luny		1/15 E11	cridge, M	Maryland
Important: If Item 27 is marked other than any injury or other treumatic avent, the Mi ones.  To Be Comp	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	no Inc		
2 d Cl	Hubbard Funeral Hom 4107 Wilkens Avenue	Baltimon	re, Maryl	and 21229
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart teilure. List only one cause on each line.	or respiratory arrest,		Approximeta Intervel Between
ician				Onset end Death
edical miner	Immediate Cause (Finel disease or condition			2 D. 31
	resulting in death)  Due to (or as e consequence of):		1	
physicien and as the burial-transit edical Examiner	b. Conjective heart tribre			2 -
EXB!	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			0 7
8			1	2
# B	resulting in death) Last  Due to (or as/e consequence of):			
attending physicien and for use as the burial-transit clan/Medical Examir	d			
d for a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	22h Did tohace	no use contribute	to the cause of death?
etached for use	r acti. Other argumetatic contributing to obtain but not resulting in the uncertainty cause given in react.			obably 4 Unknown
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cate has been signed by the attendi page 2 should be detached for use Completed by Physician/		24a. Wes an eu		Were eutopsy findings vailable prior to
2 sho		performed?		completion of cause of death?
e has age 2		1 ☐ Yes	2 1 No 1	□Yes 2/2 No
B. C.	25. Was case referred to medical 26. Place of Deet	th (Check only one)	2240	7
al director, page To Be Com	examiner?	ome 5 Residence	6 ∏Other (Spec	cify)
	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in		,,
e funa e funa e funa e funa	DNatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
To the Funeral Director: A completely filled in by the figure of the footbase	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Ste	and Number or Ru	ral Routa Number,
ed in by the funare Certification:	4 ☐ Homicide building, etc. (Specify)	City of Town, Sie	110)	
y file	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place,			
Medical Certification:	(Check only and Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occur and manner stated.	red et the time, date e	nd piece, end due	to the cause(s)
N N	29b. Signature and Itle of pertilide 29c. License number	29d. D	Date signed (Month	n, Dey, Year)
	Debak mare \$0 H0053939	11	12/29	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
V	Babak Imanoel, MD 301 Hospital Drive, Glen Burnie, Mar	vland 2106	1	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registrar	NOV 18 1999 Jeneva G. Sparks			

DHMH 1

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year Vernon W. 2:20 PM Reddish 16, 1999 November /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Elder Care Severna Park Anne Arundel If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 1 ☒ M 2 ☐ F 8. Date of Birth (Month, Dey, Year) May 5, 1914 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 85 Yrs. MaryTand Director 215-03-7266 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? Funeral 24 Truck House Road 21146 USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Race - American Indien, Bleck, White, etc. 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) hours efter 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Yaar or Detas: Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Welder 9 Steel Manufacturing end Mentel Hygide Is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 ie marked otherly Injury or other traumatic even Be William Thomas Reddish Ruth L. Bradley 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladis Bowling sister 5608 Loch Raven Blvd.Apt. A Baltimore, MD 21239 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Cemetery Nov. 19 Glen Burnie, Maryland 22. Name end Address of Fecility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licensee 3111 Mountain Road, Pasadena, MD 21122 23e. Peril. Enter the disease, or complications that cause of positive of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limb **Physician** immediata Cause (Finel disease or condition resulting in deeth) /Medical · DEMENTIA 5 Y GARG Examiner Due to (or es e consequence of): Examiner CARDIOVASCULAR ARTERIOSCIBROTIC The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Lest pue Dua to (or es e consequence of): physician s the bune Box 68760. Physician/Medical Due to (or es e consequence of): P.0. Pert II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ENCEPHALOPATHY Records. 2 24b. Were eutopsy findings evailable prior to complation of causa of deeth? Be Completed 24a. Wes en eutopsy pege 2 s 1 Yes 21400 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Other (Specify) 1 Yes 2 No Certification: To funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 DNeture 5 Pending 1 Yes 2 No Investigetion 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. Medical 29a. Certifier 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Mus NOVEMBER 17 021776 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 HANOVERST BALTIMORE 21221 SURYA MUNDRA MD 3001 S 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State NOV 1 8 1999 Registrar

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State Registrar

31. Date filed (Month, Day, Year) NOV 1 8 1999

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 99 36200

			Certifica	te of Death	Reg.	. No.	30209
Physician	Decedent's Name (First, Middle, Last)	cina Cin	MONS		2. Date of Death Month	Day Xee	3. Time of Death
/Medical	4a Facility Name (If not institution, give :		,0/0/1	4h City Town or	Location of Death	4c. County of De	7 12:10 An
Examiner	000 0 0 1	ski Stree	+	Balti	more	N	A
Funeral	5. Social Security Number 6. Sex	0101	st birthday) If Unde	r 1 Year   If Under 24 Hr	8. Date of Birth	9. B	Sirthplace (State or Foreign Country)
Director	Usual Residence of Decedent	W 20 P 80	Yrs.		April 10	,1919 M	aryland
ma 23a or 28a-f ahow r must be notified at	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
28e-f at notified rector	Maryland NIA	Balt	more				1) Yes 2□ No
0 B 0	333 S. Pulas	ki Street	c	21223	Ui	Citizen of What	States
r hema 23. pher must Funeral	11. Marital Status  1 Never Married 2 Married	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? ( city Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, WI	nerican Indian, hite, etc.
by V	3 ☐ Widowed 4 ☐ Divorced	iXYes 2□No WW If Yes, Give Year or Dates:	⊥ 1□ Yes	2 No Specify:		Specify:	Jhite
nt the Medical E.	15. Decedent's Educ (Specify only highest grade	ation (completed)	16a. Decedent's Usu (Give kind of w	al Occupation	orkina 161	b. Kind of Busines	is/Industry
mple m	Elementary/Secondary (0-12)	College (1-4or 5+)	Q. 11	ork done during most of we se retired)	T.	20,1000	1-
vent, tr	17. Father's Neme (First, Middle, Last)		brakem	18. Mother's Na	me (First, Middle, Mai	iden Sumame)	(C)
arkad ott atic ever To Be	Thomas Simr	mons		Elsie	. Unkn	nwn	
T is marked othe traumatic event, To Be C	19a. Informant's Name/Retetionship (Ty)	oe, Print)	19b. Mailing Addres	S (Street and Number or F	Jural Route Number, C		
Item 27 other tr	Florence Simo		3335.	Pulaski.			re, MD 21233
or of	20a. Method of Disposition  1 Burial 2 Cremetion 3 R	emovel from State	netery, cremetory or		111 1 1 0	Location - City of TOWNS	
Important: If I any Injury or ance	4 □ Donation 5 □ Other (Specify)  21. Signeture of Funerat Service License		22. Name a	nd Address of Facility	mbrose Fu	1	1
oor in a	Sharred M	Lange	2719	1-lammone	Is Ferru	Rd 4	ansdavne, mo
	23a. Part1. Enter the disease, or complice shock, or heart feilure. List only on	ations that caused the death. e cause on each line	Do not enter the mo	de of dying, such as cardia	ic or respiratory arrest		Approximate Interval Between Onset and Death
/sician ledical	Immediate Cause (Finel	Metastation	e Care	morna of	the col	An	
aminer	disease or condition resulting in death)		as a consequence of)		12 win	,,,,	
# Ju	_ b						
physicien and s the burlai-transit edical Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or e	es a consequence of)				
s the burl	cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or e	s e consequence of):				t
2 3	resulting in death) Last		,				
d by the attendir letached for use Physician/	d						t .
ched i	Part II. Other significant conditions con	ributing to death but not resulti	ing in the underlying	cause given in Pert I.			te to the cause of death?
be deta by Ph	Type 2 des	bela mellet	us that	volension	1 Yes	2.2110 3□	Probably 4 Unknown
	Cardina	-#			24a. Wes an e		b. Were autopsy findings available prior to
page 2 should	- ca. al sundo	arry			politonia		completion of cause of death?
Page Corr					1 ☐ Yes	2.21No	1 ☐ Yes 2 ☐ No
ector.	25. Was case referred to medical examiner?	ospitet:		Other	eth (Check only one)		
rthis or ral dire	1 Yes 2 TNo "  27. Manner of Death	1 □ Inpatient 2 □ EF	R/Outpatient 3□ D 8b. Time of	DA   4   Nursing 28c. Injury et Work?	Home 5 Residence 28d. Describe how		oscify)
ol Director: After tied in by the funari Certification:	1.☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of tnjury (Month, Day Year)	tnjury M	Work? 1 ☐ Yes 2 ☐ No			
by th	3 Suicide 6 Could not be determined	28e. Place of trijury - At hom- building, etc. (Specify)	e, farm, street, factor	y, office	28f. Location (Stree City or Town, S		Rural Route Number,
P P P							
pletaly fill	29a. Certifier  (Check only one)  1 Cartifying Physical Examin	ician: To the best of my knowle er: On the basis of examination and manner steted.	edge, death occurred n and/or investigation	et the time, date end place, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner and place, and d	as stated. ive to the cause(s)
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	29b. Signature and titte of certifier		29	c. License number	29d.	Date signed (Mo	onth, Day, Year)
UX,	1 Sevan	N	1	002004	0	11/17	199
1	30. Name and address of person who cor	npleted cause of death (Item 2	(Type, Print)	4 01	1 0 1	4	MIZIN
V	V. EVANS	my 700		gion BIV	e, pro	more	Md 21230
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	· B A	parks			

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							C	ertifica	te of	Death	R	eg. No.		0210
	Physician		ecedent's Neme (	First, Middla, Las	st)						2. Data of Dea Month		Year	3. Time of Death
	/Medical			HANS			IN				Novembe	r 15	1999	1:57pm
	Examiner		acility Name (If n		a street and nu	m <i>ber)</i>				4b. City, Town, or I	Location of Death	4c. County		
			Stella Mociel Security Num		AV	7. Aga (In yrs	last histhe	If Und	er 1 Year	Timonium  If Under 24 Hrs.	9 Date of Birth		ltimo	
	Funeral Director	214	1-12-192 I Rasidance of D	7 X		86	Yrs	Month		Hours Min.	8. Data of Birth (Month, Day June 2,	1913	Germ	laca (Stata or Foreign try) IQNY
Po ob	Mon to			0b. County		10c. C	ity, Town o	Location					11	0d. Inside City Limits
M	28a-f show out and a	Man	ryland	Baltimor	'e	Lut	hervi	11e						1 ☐ Yas 2 ☐ No
4	or 28a-fa	10e.	Street and Numb						ip Code		1	0g. Citizan of \	What Coun	try?
4	23a	860	7 Count	rybrooke					210			USA		
21215-0020	To Be Completed by Functional Director	3	Merital Status  ☐ Nevar Merried ☐ Widowed 4		12. Wes Dec Armed Fo 1 Yas If Yas, Gir Year or D	XX No	J,S. 1	if Yes, sp 1 ☐ Yes		lispanic Origin? (S en, Mexican, Puart Specify:	pecify Yes or No- o Rican, atc.)	Blac	ea - Amaric ck, Whita, a Whi	atc.
5-0	natur			5. Decedent's Ed		15-3	(G	cedent's Us	ork done	during most of wor	king	16b. Kind of B	usinass/Inc	Justry
121	ygione. No mature. No ma Medical.	El	emantary/Second		Collega (	1-4or 5+)	lif	a. DO NOT	use retired	3)				
ca 2	C P P		ether's Name (Fi	rst Middle Last)	5+		0	wner/F	resi		na (First, Middla,		xtile	Co.
aryian	Mental H Mental H Mic ever		Anton St								Rothchi		,	
	and Mental Hygins marked other burnatic event, I	-	Informant's Nam		Type, Print)		19b. M	ailing Addre	ss (Street	and Number or Ru			Stata, Zip	Coda)
C		Ama	alia R S	tein		Wife	860	7 Cour	tryb	rooke Way	/ Luther	/ille,	Maryl	and 21093
ore	of He		Mathod of Dispos		Damouel from		Place of Di cemetary, o	sposition (National or	ama of other plac	<b>&gt;e</b> )	Data	20c. Location -	City or To	wn, Stata
Pages	ant: I		DiDonation 5				laney	Valley	Memori	al Gardens	11/20/99 [	utherv	ille,	Maryland
Baltimore,	point regos is and should be more waiting the partition of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mannes.  To Be Compl	21.	Canalian of Fune	ral Service Hoen	slend	leno.	ker			ss of Facility M k Road Ba				Home Inc. 1212
		23a	Part1. Enter the shock, or heart for	diseesa, or comp	olications that o	aused the dea	th. Do not			g, such es cardiac				Approximata Intarval Between
200	hysician													Onsat and Death
	/Medical xaminer	disa	ediate Ceuse (Fir asa or condition Iting in daath)	nal	a. AL	ZHEIMI	ERIS							
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Box	for use				d		1.39							
0 9	igned by the attendin be detached for use by Physician/N	Part	l. Other significa	nt conditions co	entributing to de	eath but not ras	sulting in th	a underlying	causa giv	en in Part I.	23b. Did to	obacco use co	ntribute to	the cause of death?
P. P.				/			-				1 🗆 Y	es 2 No	3 ☐ Prot	bebly 4779nknown
I Records, P.O. Box	ate has been signe page 2 should be of	-	Esu s	10000	24/00		1100	92			24a. Was a	n autonsv	24b. Wa	ara autopsy findings
000	should should leted		11								perfor		ava	ailabla prior to mpletion of cause death?
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of Vita	s certificate he director, page		xaminar? □Yas 2ĀNo		Hospitel:	npatiant 2	ER/Outpa	tient 3 🗆 🖸	OA Oth	er: * Nursing H			ar (Specifi	v)
ion of		27. N	lannar of Death  Natural  Accident	5 Panding invastigation	28a. Data (Mon	of Injury th, Day Year)	28b. Time Injur	a of	28c. Injur Wor	y at k? Yas 2 □ No	28d. Dascribe h			
Division of or Attending	is after death.  I Director: After the in by the funeral Certification:	3		6 Could not be datarmined	25a. Flace	of Injury - At h	oma, farm,	street, facto	ry, office		28f. Location (S City or Town		per or Rura	l Routa Number,
e Hospita	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		Cartifier (Check only one)	XCertifying Phy	iner: On tha ba	best of my kno asis of axamina nar stated.	owledga, de ation and/or	eath occurred investigation	d at the tin	na, data and place pinion, death occu	, and dua to tha c rred at tha tima, d	ausa(s) and ma ata and place,	annar as st and dua to	ated. tha cause(s)
Toth	To the comp		Signature and I	ol codilion	loss	4		25	D 1	5 5 0 4	2	9d. Date signe	d (Month,	Day, Year)
	A	30. N	ame and addrass	of person who o					ey V	alley H	Rd Tim	onium,	Md	21093
	State Registrar	31. D	ata filed (Month,	Day, Year)		egistrer's Sign	etura	4 A	port	W				

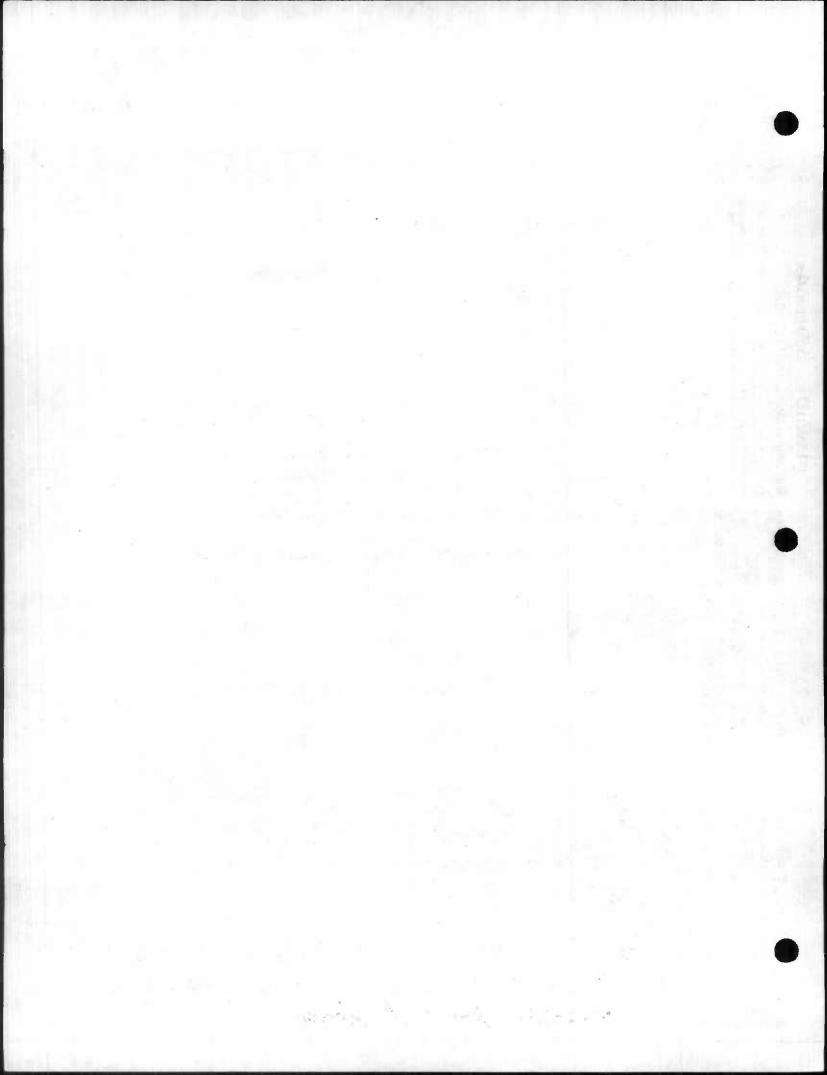
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				Certifica	ate of	Death		Reg. No.	000	411
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edical	EDWARD	EARL		STILL	MAN		Nevemb	1	1997	10:45 A
miner	4e Facility Neme (If not institution, give						or Location of Death		y of Death ARUNDE	Т
	NORTH ARUNDEL HOS  5. Social Security Number 6.5			edaul H Uni	der 1 Year	GLEN BU				
	244-20-3880	M 2□F	ga (In yrs. last birti 74	rs. Month			JULY 24	,1925	NORTH	CAROLINA
	Usual Residence of Decedent  10a. Stata 10b. County		10c. City, Town	or Location					10d.	Insida City Limi
5	MARYLAND ANNE ARI	INDFI.	GLEN B	URNTE						1 Yas 2 N
Director	10e. Street and Number	J. L. D. L.	OBEN B		Zip Code			10g. Citizen of	What Country	?
O	7633 9TH COURT			2	1061			U.S.A.		
by Funeral	11. Maritel Status  1 □ Nevar Married 2 ☒ Married	12. Was Decedent Armed Forcas 1 (∑ Yas 2 ☐ If Yas, Giva	No 1944-		cedent of pecify Cut		(Specify Yes or No- lerto Rican, atc.)	Spanific		
	3 Widowed 4 Divorced	rear or Deles.	40						WILL	
Be Completed	15. Decedent's Ed (Specify only highast gra	ducation ada completed)		Decedent's U Giva kind of lifa. DO NO!	work done	during most of	working	16b. Kind of b	Businass/Indus	itry
die	Elementery/Secondary (0-12)	College (1-4or	5+)	S DRIV		~~/		TRANSI	PORTATI	ON
ŏ	17. Father's Name (First, Middla, Last,	)	100	D DILLY		18. Mother's i	Name (First, Middle,			
O B	JOHN MILI	ARD	STILLMA	N		LOAR	MAY	KI	EECH	
-	19a. Informant's Name/Ralationship (				ess (Stree		Rural Routa Numbe			ode)
	KATHLEEN POTTER-		7	633 9T	H COI	URT, GLE	N BURNIE,	MARYLA	AND 210	61
	20a. Mathod of Disposition		20b. Place of	Disposition (#	lama of		Data		- City or Town	
	1 ☐ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specif		GLEN HA	VEN ME	MORI.	AL PARK	11-19-99	GLEN B	URNIE,	MD
	21. Signature of Kunamingervice Licer	*					<u>i.                                    </u>			
900	· / VD-/	7	_				SINGLETON			
	23a. Part / Entail the discount of com shock, or heart blue. List only	ev	date death Dea				., GLEN B			oproximata
burial-transit	Sequentially list conditions,	b	Dua to (or as a co	onsequence o	n):				1	
edical Ex	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants	c	During for a second		0.				1	
	rasulting in death) Last	d	Dua to (or as a co	risequence o						
Physician/N	Date Office Land									
Jys	Pert II. Other aignificant conditions of	ontributing to death b	out not resulting in	tha underlyin	g cause gi	ven in Part I.			. /	e cause of deat
by Pl							_   ''	/es 2□No	3 Probab	oły 4 □ Unkne
Completed b							24a. Was perfor	an eutopsy med?	availa	eutopsy finding ble prior to letion of cause eth?
m C							450	456		
	25. Was casa referred to medical						101		1 U Y	as 2 No
D Be	axaminer?	Hospital:	• • • • • • • • • • • • • • • • • • •		Ot Ot	hor	Death (Check only o	- 1		
: To	27. Manner of Deeth	28a. Data of Inju		SOCIETY IN THE	DOM	4 LI NUISIN	g Home 5 Resid			
ation	1 Netural 5 Pending 2 Accident investigation	(Month, Da	y Year) In	ury M	28c. Inju Wo 1	rk? ]Yes 2□No	200, 2000,200	ow injury occu		
Certification:	3 Suicide 6 Could not be detarmined	28a. Place of in	ury - At homa, fari c. (Specify)	n, street, fact	ory, office		28f. Location (S City or Tow	itreet and Num n, State)	ber or Aural A	louta Number,
edicai	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis of end mannar st	f examination end	death occurre or investigati	ed at the to	ime, data and plo opinion, death o	ace, and due to tha c ccurred at the time, o	ause(s) and mate	nannar as state , and dua to the	ed. a cause(s)
M	29b. Signatura and titla of certifier	ONO MAINE OF	400.	1	9c. Licen	se number		29d. Date sign	ed (Month, Day	y, Year)
	1 ARA	MA	٨		04	2977	1		, 11	1949
	NBY	11/1	J		V (	)	1	Wem	10ex 16	1111
	30. Nama and address of person who	completed cause of	eath (Item 23a) (1	ype, Print)	CD	1	\	A N	m/1	
	31. Dete fied (Month, Day, Year)	1 201 7	TOPMIC	show.	96	n Alwy	ne in	1. 2	1061	
		32 Registr	ar's Signature		-					



<b>lease Typ</b> St	e or Print In B	lack Indelible ink. Assure	All Copies Are Legible.	36212
		Certificate of Death	Reg. No.	
Aiddle, Last)	Howard	Solli	2. Dete of Death Month Day Year November 14 1999	3. Time of Deat

Physici /Medi Examir

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow eny Injury or other traumatic event, the Wedical Exercises must be notified an once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be associted mills 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit State

					Certifica	ate of	Death			Reg.	No.			
1. Decedent's Nam	e (First, Middle	, Last)							2. Dete of De				3. Time	of Death
	Andrew	. 1	Howard	S	olli				Month Novemb		Day 14. 1	Year	3:00	D M
4a Facility Nama (					OIII		4b. City. To	wn. or L	ocation of Deat		4c. County		13.00	1 .11.
				,			-							
		Maryland			day I H I In	der 1 Year	Balti				- 1	I/A		
5. Social Security N		6. Sex 1 XM 2 ☐ F	7. Age (In yrs.		Monti		Hours	Min.	(Month, D	ay, Ye		9. Birth	place (State ntry)	or Foreig
213-18-3			80		3.				Sept 1	6,	1919	Mar	ryland	l
Usual Residence o 10a. State	10b. County		40a C	in Town	or Location								and toolds	Ola . 1 ! !a-
Toa. State	100. County		100. 0	ity, Town C	DI LOCATION								10d. Inside	
Maryland	Car	roll			Ham	pstea	d						I LI Ye	s 2 N
10e. Street end Nu	mber				10f.	Zip Code				10g.	Citizen of	What Cour	ntry?	
2545 B	ert Fow	ler Road				21	074				U.S	.A.		
11. Meritel Stetus		12. Wes Dec	cedent Ever in L	J.S.	13. Wes De	cedent of I	lispanic Or	igin? (Sı	pecify Yes or No	0-	14. Rac	e - Americ	can Indian,	
1 Never Merr	ied 25 Marri	Armed F	orces?		If Yes, s	pecify Cub	an, Mexica	n, Puerte	o Rican, etc.)		Ble	ck, White,	etc.	
3 Widowed		If Yes, G	ive	тт	1 ☐ Yes	2 No	Specify				Specif	y: T	White	
			Dates. W W							100	Kind of B			
(Spec	15. Decedent city only highes	is Education of grade completed,	)	(0	ecedent's U Give kind of	work done	during mos	t of wor	king	160	. Kind of B	usiness/in	dustry	
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12			)_	Gen	eral	Super					Const		.on	
17. Father's Neme	(First, Middle, L	Last)					18. Moth	er's Nen	ne (First, Middle	, Maid	den Suman	ne)		
Hans		Solli						K	ristine	e Me	oun			
19a. Informent's No	eme/Reletionsh	nip (Type, Print)		19b. N	Mailing Addr	ess (Street	and Numb	er or Ru	ral Route Numb	oer, Ci	ty or Town,	Stete, Zip	Code)	
Mrs. Vel	lma Sol	1 i		25/	5 Rer	t Fou	ler P	nad.	Hampst	024	I. MD	210	174	
20e. Method of Dis			20b.	Plece of D	Disposition (	Varne of		Jud	Date	r	Location			
1 XBurial 2	Cremetion	3 □Removel from	State	cemetery,	crematory o	or other ple								
4 Donetion	5 Other (Sp	pecify)	Lak	ce Vi	ew Mei				11/19	Sy	kesv:	ille,	MD	
21. Signature of Fu	ineral Service L	Licensee	11 -				ss of Fecili	•						
1 10	relin.	mys	ukins						l Direc				11100	
23a. Pert1. Enter t	he disease, or	complications that	caused the dee	th. Do no	enter the n	node of dvi	ng, such as	cardiac	Randall or respiratory	SEC	own,	MD 2	Approxima	ete
shock, or hea	irt feilure. List o	only one cause on	each line.									1	Onset end	
Immediate Ceuse of disease or condition	on	5	in dim	00	hemi	nle	82					1		
resulting In death)		0.			nsequence		8					1		
Cognostially list on	aditions	<b>b</b> . —	Due to (	or as a cor	nsequence	ηf)·						1	_	- 191
Sequentially list co if any, leeding to in cause. Enter Under	nmediate											1		
Cause (Diseese or thet initieted events	Injury	c	0.115.4											
resulting in death)	Last		Due to (d	or es e cor	nsequence o	of):								
		d												
Pert II. Other signif	icant condition	ns contributing to o	leeth but not res	sulting in t	he undertyin	g cause giv	en in Pert	1.	23b. Did	tobac	cco use co	ntribute t	o the cause	e of death
									1	Yes	2 No	3 Pro	bably 4	Unknow
									24a. Wes				ere autopsy	
										omed		CC	vailable prior ompletion of	
										/			death?	
									10	Yes	2 🗆 No	11	Yes 2	□No
25. Was case refer	red to medical						26. Plac	e of Dee	th (Check only	one)				
examiner? 11☑ Yes 2□	No	Hospitel:	Inpatient 2	ER/Outp	atient 3	DOA Ott	oer _		ome 5□ Res		e 6 □0#	ner /Sneri	fv)	
27. Menner of Deat		28a. Dete	of Injury	28b. Tin				arang H	28d. Describe	_			"	
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2 Accident 3 ☐ Suicide	6 Could n	ot be	3-99	125	01		.00 2	. 10					nt Days	ion by a s
4 Homicide	determi	ned 28e. Plec	a of Injury - At h ling, etc. (Speci	nome, term	n, street, fec	tory, office			28f. Location City or To	wn, S	t and Numi tete)	oer or Hun	ai Houte Nu	imber, H
			STA						12384±	Dis	MOON	MRD	CAR	מסנונט
29a. Certifier (Check only		Physician: To the												(-)
one)	AXI Medical E	Examiner: On the band men	pasis of examination of the state of the sta	ation end/o	or investigat	ion, in my d	pinion, dea	ith occu	rred at the time	, date	end plece,	end due t	o the cause	e(s)
29b. Signature end	title of certifier					29c. Licens	e number		I	29d.	Date signe	d (Month,	Day, Year)	)
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MOU	me 1	and 2016				O	· C • 1 · 1 · .	•		TAO	v Chibe.	r T),	エノフフ	
30. Neme and addr	ess of person w	who completed cau	se of death (Iter	m 23a) (Ty									0	
MARGA	ans	H. KOR	Ele f	en	111	Penn	Stree	t, E	Baltimor	æ,	Mary	Land	21201	
31. Dete filed (Mon		32.1	Registrar's Sign	eture	1	1								
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 99

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		Cen	tificate o	f Death		Reg. No.		
	Decadant's Nama (First, Middla, Last)				2. Date of Da			3. Tima of Daath
Physician	TSAAC	54	AVER	5	Month	Day	Yaar 1999	9 45 A
/Medical	4a Facility Nama (If not institution, give street and number)	211	TVCK	4b. City, Town, or L			-	
* Examiner		HOSPI						
			If Undar 1 Ya		7 more			10
ineral	4 T M 6 T F	s. last birthday)	Months Day		8. Data of Bi (Month, D.	ay, Year)	Counti	aca (Stata or Foraign
ector	219-56-44/2	Yrs.			FEB.	9.1951	MARYL	JAND
	Usual Residence of Dacedant	Mr. Town and an	-41				100	ad de al de Otto de la lacina
JC 85	10a. Stata 10b. County 10c. C	City, Town or Loc	ation				10	d. fnslda City Limits
Ş	MARYLAND N/A	Е	BALTIM	ORE				1 ☐ Yas 2 ☐ No
Director	10e. Street and Number		10f. Zip Code	а		10g. Citizen of V	Vhat Counti	ry?
	MILLENNIUM HEALTH ABD RE	EHAB.	2	1000		IJ.	S.A.	
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5	Armed Forcas?	If If	Yas, specify C	of Hispanic Origin? (Sp Juban, Maxican, Puarto	Rican, atc.)	Blac	k, Whita, a	tc.
by F	↑ Nevar Marriad 2 Marriad 1 Yas 2 No If Yas, Giva Yaar or Datas:	1	□ Yas 25	lo Specify:		Specify	/- AME	RICAN
ete	15. Dacadant's Education (Specify only highast grada completed)	(Giva k		na during most of work	ing	16b. Kind of Bu	usinass/Indu	ustry
Completed	Elementery/Secondery (0-12) College (1-4or 5+)	lifa. D	O NOT usa ret	(ired)				
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Be	17. Fathar's Nama (First, Middla, Last)		021	RE PROVII	e (First, Middle	a, Maidan Sumam	ia)	
0	HOWARD SHAVERS SR.			TRENE	EURE			
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	MARCEL HALL/SISTER			GTONAVE.				
					Date	20c. Location -		
	20a. Mathod of Disposition 20b.  1 Seburial 2 □ Cramation 3 □ Ramoval from Stata	Place of Dispos cematary, cram	etory or other	plece)	Date	Zoo, Education -	JRY 01 10W	, Ound
	4 ☐ Donation 5 ☐ Othar (Specify)	. ZTON	CEME!	TERY NO	OV.22.	1999 BA	LTO.	MD.
ģ	21. Signature of Funeral Service Licensee /	22.	Nama and Ad	drass of Facility				
any injury o	May 1 :7/4.	, 0	ALVIN	B. SCRUC	GGS FU	NERAL H	HOME	
	23a. Part1. Entar tha disaasa, or complications that caused tha do shock, or haart failure. List only one cause on each line.	24	412 E	PRESTON	STRE	ET BALT	O, MD	21213
	shock, or haart failure. List only one cause on each line.	nn Do not anta	r tha moda of c	lying, such as cardiac	or raspiratory	arrast,		Intarval Batween Onsat and Death
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10	Inpatiant 21	ER/Outpatient	3LI DOA	4   Nursing H		idanca 6 Oth		7
OU	27. Mannar of Death 28a. Data of Injury (Month, Day Year)	28b. Tima of Injury		njury at Work?	Zou. Dascribe	how injury occur	180	
ati	2 Accidant invastigation		M 1	I□Yas 2□No				
H	3 ☐ Suicida 6 ☐ Could not be determined 28a. Place of Injury - At building, atc. (Spec	homa, farm, stre	et, factory, offic	ce	28f. Location	(Street end Numb own, Stata)	per or Rural	Routa Number,
Certification:	Dullaing, atc. (Spec	my)			Only Or 10	our, otara/		
ai C	29a. Certifiar criifying Physicien: To the best of my kr	nowledge, death	occurred at the	a tima, data and place.	end due to the	e ceuse(s) end ma	anner es ste	etad.
edicai	(Check only 2 Medical Examiner: On the basis of axaminen one)							
ĕ ¥	29b. Signature and titla of certifier		29c 1 ics	ansa number		29d. Data dgne	d (Month F	Dav. Year)
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	phillione 1	M	112	2052		11/11	17	9
	30 Name and addrass of person who completed cause of daeth (Ite	em 23a) (Type, P	Print)	11-	+	2 k 6	3/1/1	omo
	KOBERA J WILLIAMS	560	2 BA	Straneri	THUMOT F	ye ?	2/2	28
State	31. Data filad (Month, Day, Yaar) 32. Ragistrar's Sign	natura	,					
strar	NOV 1 8 1999 Dener	a B	100	ela/				
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State of Maryland / Department of Health and Mental Hygiene 36214 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 6:50 AM MARLENE STIERHOFF u /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner 24 Byway Rd. Owings Mills Baltimore If Under 1 Year | Months Days If Under 24 Hrs. 8. Date of Birth
July 16, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Hours Maryland 68 216-28-2397 Director Usual Residence of Decedent the Maryland permit. Peges 1 and 2 ahould be filed within 72 hours efter death with the Marylan Department of Heelth and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow with fujury or other traumatic event, the Medical Examinat must be notified at page. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Maryland Owings Mills Baltimore Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Byway Rd. 21117 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baitimore, Maryland 21215-0020 Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimere Co. Public Elementary/Secondary (0-12) College (1-4or 5+) Schools Transportation Dispatcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Green Daisy Griswald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Byway Rd. Owings Mills, Md. 21117 Harry H. Stierhoff - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LakeView Mem. Park Nov. 19,1999 Sykesville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 Huth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) RENAL Cell CARLINOWA months Examiner Examine physicien end s the burlei-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Pas 20 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and appress of person who completed cause of death (Item 23a) (Type, Print) St. , Salpmone, S. GREENE 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

NOV

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Day Year **Physician** Henry Stelmack November 16 1999 5:30 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1948 Frames Rd Dundalk Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthpiace (State or Foreign Country) **Funeral** Days 10XM 2□ F Months 71 Director 219-22-2728 June 14 1928 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r 28a-f show Instilled at 1 ☐ Yes 2 ☑ No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23s or the Medical Examiner must be 1948 Frames Rd 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, atc. filed within 72 hours after Hygiene. Ither than "natural", or itse 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled w Capartment of Health and Mental Hygien Important: if Item 27 is marked other th. any injury or other traumatic event, the once. Diesel mechanic Trucking 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Stelmack Laura Kowalski 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Constance Stelmack /wife 1948 Frames Rd Baltimore, MD 21222 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Nov 19 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Part1. Enter the disusse, or complications that caused the doubt. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Acute Hyormalian MINUTES Examiner Examine 20 years disensa PANKANO PUZRY physician and s the burial-transit that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 3 Probably 4 Unknown 1 Yes 2 No Metastate Division of Vital Records. Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☑ No 1 Yas 2 No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 4 hours after death. Funeral Director: After the 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) Ain 24 hou.
The Funeral Dr.
Tilled in by 4 Homicide Hospital 29a. Cartifier Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. \$ 29b. Signature 340 29c. Licensa number 29d. Data signed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

2

1792 Merritt Blvd

1

M.D.

32. Registrar's 3

30. Name/and addrass of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Richardson,

31. Date filed (Month, Day, Year)

NOV 1 8 1999

November 17, 1999

Baltimore, MD 21222

ysician			st) ELEANOR MAI	RIE STANT		2. Data of Death Month	Day Yaar	3. Tima of Death
1edical		Eleanor  a Facility Nama (If not institution, given	Stanton-		No. City, Town, or Loc	vember	17 1999 4c. County of Deat	
aminer	48							
eral	5	Genesis - Her:			Dundall r 1 Yaar   If Undar 24 Hrs.	8. Data of Birth (Month, Day, )	Baltir 9. Birt	NOTE hplace (Stata or Foraig untry)
or		217-14-2509	□M 2⊠F	76 Yrs. Months	Days Hours Min.	Dec 12,	1922 M	
	_	sual Residence of Decedent	1.2					
7		Oa. Stata 10b. County		y, Town or Location				10d. Insida City Limits 1 ☐ Yas 2 ☑ No
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Funeral Director	"	6819 Bessemer	7110	10f. Zip	21222	101	g. Citizen of What Co USA	untry
era	1	1. Marital Status	12. Was Decedent Evar in U.	S. 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Maxican, Puarto R	cify Yas or No-	14. Race - Ama	
2		1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Datas:	If Yas, spe		lican, atc.)	Black, White Specify: Wh	a, atc. nite
2		15. Decedent's E	ducation	16a. Decedent's Usu	al Occupation	16	5b. Kind of Businass/	Industry
	-	(Specify only highast gra Elementary/Secondary (0-12)	College (1-4or 5+)		ork dona during most of working se retired)	g		
1		12		Homemak			Own Hom	е
e		7. Fathar's Nama (First, Middla, Last			18. Mother's Name			
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	1	9a. Informant's Name/Relationship (			S (Street and Number or Rural			
or other traumatic event, the land	20	George Stanto Oa. Mathod of Disposition	20b. P	lace of Disposition (Na	berty Pkwy.	Data 20	Dc. Location - City or	
		1 ☑ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		K Lawn Ce	metery No	v 18 1999 B	altimore	MD
	2	Signature of Funeral Sarvice Licer	· 0 a	22 Nama ar	nd Addrass of Facility		Baltimore	
		10+11 (	00	Conr	nelly Funera			alk
-	2	23a. Part1. Entar tha disease or com	plications that caused the death		Sollers Po			Approximata
	le	shock, or heart tailura List only mmediata Causa (Final			00101911	1		Intarval Batween Onset and Death
	d	liseasa or condition asulting in death)			ASPIRATION			
her			(ERFR	r as a consequence of):	DEGENE	RATIN	11 -	
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65	i S	sequentially list conditions,	Dua to (o	r as a consequence of):				
		dequentially list conditions, any, leading to immediata ause. Enter Underlying	Dua to (o	r as a consequence of):			J. L.	
Ca	t	dequentially list conditions, any, leading to immediata ause. Enter Underlying cause (Disease or injury nat initiated events assulting in death) Last	C	r as a consequence of): r as a consequence of):		- 16		
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E S	t	ause (Disease or Injury nat initiated events	C					
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edical Certification: To Be Completed by Physician/Medical	Pri Pri 29	ause (Disease or Injury nat initiated events asulting in death) Last  5. Was casa referred to medical axaminer? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending invastigation 3 Suicide 6 Could not be detarmined  9a. Cartiflar (Check only one)  9b. Signatura and title of certifier	Dua to (of d	ER/Outpatient 3 DC 28b. Time of Injury M Doma, farm, street, factor //)	26. Placa of Death  OA Other: 4 Nursing Hom  28c. Injury at Work? 1 Yas 2 No  y, office 2  at the time, date and place, at h, in my opinion, death occurre	24a. Was an performed 1 Yas  (Check only ona), as 5 Rasiden 8d. Dascribe how 8t. Location (Stree City or Town), and due to the caud at the time, dat	autopsy 24b.  autopsy 24b.  2 No 3 P  autopsy 24b.  2 No 2 No 24b.  2 No 24b.  2 No 24b.  2 No 3 P  autopsy 24b.  24b.	wara autopsy tindings available prior to complation of causa of death?  1 □ Yas 2 □ No  city)  ural Routa Number,  s stated. to the cause(s)  h, Day, Year)  — 9 G

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		,,,,,	Certific	ate of Death	Re	g. No.	9 36217
Physician /Medical	1. Decedent's Name (First, Middla, Las LARRY	•	TRUESD	ALE	2. Data of Death Month NOVEMBE	Day	Yaar 999 5:26 PM
Examiner	4a Facility Nama (If not institution, give THE JOHNS HO		PITAL	4b. City, Town, or BALTIMO	Location of Death	4c. County	
Funeral Director	5. Social Security Number 6. § 214 56 7782	ax 7. Aga (In yrs.		nder 1 Yaar   If Undar 24 Hrs	s. 8. Data of Birth	Year)	9. Birthplace (Stefa or Foreign Country)
a-f ahow filed at	Usuat Rasidance of Decedant  10a. Stata , 10b. County  M		by, Town or Location				10d. tnsida City Limits 1 ☐ Yas 2 ☐ No
3a or 28 at be not	10e. Street and Number 10 32 New Ho	pe Cvicle	101	Zip Coda 2 1202	10	Og. Citizen of W	
al', or items 23a or 28a-f show Everalner pout be notified at by Funeral Director	11. Maritat Status  14 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Evar in U Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puess 2 No Specify:	Specify Yas or No- rto Rican, atc.)	14. Race	- American Indian, k, Whita, atc.
oted	15. Decedant's Ed (Specify only highest gra	ucation da complated) Collega (1-4or 5+)	0	Jsuat Occupation work dona during most of wo T usa retired)	orking	16b. Kind of Bu	sinass/Industry Power
traumatic event, ma Market To Be Comp	17. Fathar's Nama (First, Middle, Last) Paul Druls	dale	CONN	18. Mother's Na	ame (First, Middle, M	Maiden Sumem	a) 7
item 27 is me other traum	19a. tnformant's Name/Retationship (1	Type, Print) ale	19b. Meiling Add	oress (Street and Number or F		City or Town,	
· 6	20a. Mathod of Disposition  1 Buriat 2 Cremation 3 4 Donation 5 Other (Specify	Ramoval from Stata	Place of Disposition comatery, crematory	(Nama of or other place)			City or Town, State me
any injury	21. Signatura of Funarat Sarvice Licen	Locks. J	22. Nam	a and Addrass of Facility  h b. Lerks	Ju 3/11	304 h	. Rentral A
sician	23a. Raf1. Entar tha disaasa, or comp shock, or haart failura. List only	plications that caused the dear ona cause on each line.	th. Do not enter the	mode of dying, such as cardia	ac or respiratory arra	ast,	Approximata Intarval Batween Onset and Death
dical niner	immediate Cause (Final disaasa or condition rasulting in deeth)	a. Alcoholic	- Hepa				2 weeks
s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants			2 weeks			
6	Cause (Disease or injury that initiated evants resulting in death) Last	Dua to (c	or as a consequance	of):			
Physician/M	Part II. Other significant conditions co	ontributing to death but not ras	ting to death but not rasulting in tha undarfying causa givan in Part I.				tribute to the cause of death?
be datact by Phy	Retrovival sy	ndrome	= 1,533		1 □ Ye	2 <b>₹</b> No	3 ☐ Probably 4 ☐ Unknown
2 should pleted	Hepatitis B	- <	2.97	24a. Was ar perform	24b. Wara autopsy findings available prior to complation of cause of daath?		
tor, page	Schizophrenie				1 □ Ya		1 ☐ Yas 2 No
000	25. Was case rafarred to medical examinar?	Hospital:	ER/Outpatient 3	Other	eth <i>(Check only on</i> Homa 5 ☐ Raside		ar (Snecify)
	27. Mennar of Death  1 Senatural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe ho		
al Director: Aftar tiled in by the funera Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide datarmined	28e. Plece of Injury - At h building, etc. (Specil	28f. Location (St. City or Town	reet and Number, Stata)	er or Rurel Route Number,		
ne Funer plataly fil edical	29a. Cartifiar 1⊠-Certifying Phy (Check only one) 1⊠-Certifying Phy 2□ Medical Exam	reician: To the best of my kno iner: On the basis of examine and manner stated.	wledga, daath occur ation and/or invastiga	red at tha time, data end plac tion, in my opinion, deeth occ	e, end dua to the ca surred et the time, da	use(s) and me ate end plece, s	nnar as steted. and due to the cause(s)
Toth	29b. Signatura and title of certifiar			29c. Licansa number	25	9d. Data signed	i (Month, Day, Year)
1	K. Jauba 30. Nama and addrass of person who o	The PHYSIC		RES- 000		Nove	nber 12, 1999
State	Yystan Fair (Month, Day, Year)	banks Joh 32. Registrar's Signa	ns thoris	ns Hospital 6	00 N. UX	HEST	. Balti, MS 2128



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Deeth Month 4:36 pm DAVID November 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Johns Hopkins
5. Social Security Number 6. S Baltimore Hospital City 7. Aga (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign
 Country) 219-02-861 Days 1.2M 2□ F Yrs. 6 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Burnie 1 Yas 2 KNo 10e. Street end Number 10g. Citizen of Whet Country? Kay 21061 Inited States 12. Was Dacedent Ever in U,S. Armed Forces?, 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian Bleck, Whita, etc. 11. Marital Status Was Dacadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) tudent 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Peggy Michael loomer Brown 19b. Mailing Address (Street end Number or Aurel Route Number, City or Town, State, Zip Code) Raylene Glen Burnie MD 21061 David M. Loome 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State Meadowridge Memorial Dorsey, Nayland Donetion 5 Other (Specify) 11/19/1999 22. Name and Address of Fecility Ambrose 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. sdowne mo21227 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onsat and Death Immediate Ceuse (Final 3 days 15414MIL disease or condition resulting in death) Due to (or es e consequance of): Cardiac amest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated avents resulting in death) Lest Due to (or es a consequence of): pulmonan nemore have Due to (of es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown lung transplant 24b. Were autopsy findings eveileble prior to 24a. Was en eutopsy performed? completion of cause of death? 2/X No 2 | No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatiant 2 ER/Outpetlent 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner buriel-transit The law requires that the deeth certificete be executed P.O. Box 68760, ettending physician for use as the burie signed by Records, cete hes been sig , pege 2 should b this certificete Division of Vital Hospital or Attending Physicien: director, After s efter death.

**Physician** /Medical

> Examiner Physician/Medical þ Be Completed Certification: To

To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!, or items 23e or 28a-f show any injury or other treumatic event, in a Medical Example must be nothing.

Baltimore, Maryland 21215-0020

State Registrar

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Phyelclan: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end manner stated. Medical 29a. Certifier

29c. License number 29d. Dete signed (Month, Day, Year)

29b. Signeture and title of certifier D0051118

erson who completed cause of death (Item 23a) (Type, Print)

North Wolfe St. , Baltimore MD J. Schwette, MD 32. Ragistra 's Signature

**DHMH 16 Ray 6/95** 

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99

sician	_	Decedent's Nam	ne (First, Middle	e, Last)			ertificate of	Dout		2. Date of Dec	Reg. No. ath Day	Year	3. Time of Death	
Physician /Medical		MARTIN DAVID TRUESDALE, SR.							Novem	when 13, 1999 1:5				
miner	40			n, give street and a					wn, or Loc FIMOR	cation of Death LE	4c. County			
ral tor		Sociel Security N		6. Sex 12 M 2 F	7. Age (In yr:	s. last birthda 51 Yrs.	Months Deys		24 Hrs. Min.	8. Dete of Birt (Month, Da 9-17-48	h v. Year)	9. Birthpla Counti	ace (State or Foreign ry) MD.	
	-	sual Residence o Da. State	Decedent 10b. County		10c. C	City, Town or	Location					10	d. fnside City Limits	
Meda		MD.	N/A			ALTIMO							1√2 Yes 2 □ No	
Irec	10	e. Street and Nu					10f. Zip Code				10g. Citizen of What Country?			
alD		1636 HOI	LBROOK	ST.			2120	2			USA			
ar than "natural, or have 23e or 28e/s t, the Medical Examiner must be notified Completed by Funeral Director		I. Maritel Stetus  1 Never Marr  3 Widowed		Armed 1 1 Ye If Yes,	ecedent Ever in Forces? In Society Process Pro	U,S. 13	3. Was Decedent of If Yes, specify Cul  1 ☐ Yes 2 ☐ No	oan, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)	Blac	e - America k, White, e	tc.	
			15. Decedent	's Education	- 1	16e. Dec	edent's Usual Occupation					nd of Business/Industry		
	-	(Spec Elementery/Second	city only highes	t grade complete	College (1-4or 5+)			cind of work done during most of working ONOT use retired)  FRONICS TECHNICIAN						
Sol								7			ELECTRICAL			
ic event		17. Father's Name (First, Middle, Last)							e (First, Middle, Maiden Sumame) DLYN SCOTT					
	19	9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,							State, Zip	Code)				
									VE. B	BALTIMORE, MARYLAND 21225  Date   20c. Location - City or Town, State				
	20		Cremation		m State	cemetery, c	rematory or other pla		ve 11				on, State S, MARYLAN	
	21	1 Serial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee / 22. Name and Address of Facility P												
		Torothan O Home 1721-27 N. MONROE												
	2	3a. Parl 1. Enter t	the disease, or	complications tha	at caused the de	eth. Do not e	enter the mode of dy	ing, such es	cardiac o	r respiretory a	rrest,		Approximate	
		ebook, or hea	art failure. List	only one cause of	n each line.								Interval Between Onset and Death	
	Im	nmediate Cause	(Final											
niner	resulting in deeth)  Due to (or as a consequence of):									141				
_	Le	isease or condition esulting in deeth)	on	8	Due to			Lury	Cw	ner		1		
miner	Le	esulting in deeth)	on	a		(or as a cons	sequence of):	Lury	Cw	ne		1		
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Completed by Physician/Medical	So it can Co the re	equentially list coany, leading to muse. Enter Unidause (Disease value) authorized event southing in death)  art ff. Other significant ff. Other significant files of the southing in death)	onditions, mmediate erfying r Injury s Last	a	Due to	(or as a cons	sequence of):	iven in Part I	j.	23b. Did	Yes 2 No	3 Prob	re eutopsy findings ilable prior to no cause leeth?	
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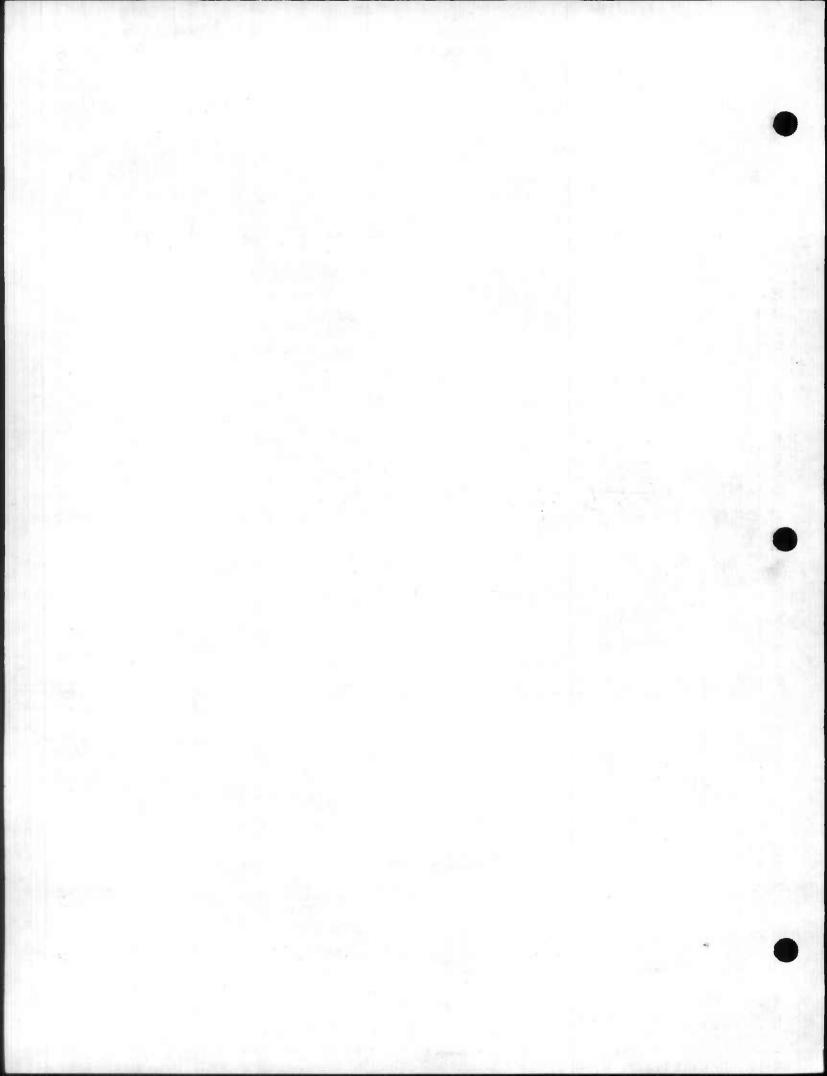
State of Maryland / Department of Health and Mental Hygiene O 36220 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Joseph L. Venanzi November 15, 1999 10:05 P.M /Medical 4c. County of Death 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Rosedale FRANKLIN Souare Hospital Center BAltimore H Under 24 Hrs. 8. Date of Birth Hours Min. March 15, 1925 ff Under 1 Yaar 5. Sociat Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplece (Steta or Foreign **Funeral** Days 1 M 2□ F Months Mary Land 74 219-16-2663 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show MD N/A Baltimore 1 St Yes 2 □ No Director 10e Street and Number 10f Zip Code 10a. Citizen of Whet Country? or thems 23s or 5026 Frankford Avenue 21206 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 N Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Cath Elementery/Secondary (0-12) Cottege (1-4or 5+) (Electrical) Mechanic City of Baltimore Department of Health and Mental Hygis Important: If Item 27 is marked other PNANZI 17 Fathar's Neme /First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 should be fi and Mental h Louis Venanzi Julia Carlontonia 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5026 Frankford Avenue Baltimore, Maryland 21206 Frances M. Venanzi/Wife 20b. Plece of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 □ Cremetion 3 □ Removel from Stete Gardens of Faith Cemetery 11/18/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility John C. Miller Inc. 21. Signeture of Funeral S 6415 Belair Road Baltimore, Maryland 21206 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finat DAYS diseese or condition resulting in deeth) Examiner Examiner ole attending physician and for use as the bunal-trensit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) P.O. Box 68760. Physician/Medical Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? signed by 1 □ Yee 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attanding Physician: Be 25. Was case refarred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ₺ Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Affer 1 Neturet 5 Pending deeth. 1 ☐ Yes 2 ☐ No Investigation hin 24 hours after deeth.
the Funeral Diractor: Ampletaly filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Ptece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. To the P within 2 To the F complet 29d. Dete signed (Month, Dey, Year) 29b. Signatura and title of certifiar 29c. License number November 15, 1999 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore MD. 21237 Borrello M.D. IVAN 31. Date filed (Month, Dey, Yaer) 32. Registrer's Signature souls

State Registrar

**DHMH 16 Rev 6/95** 

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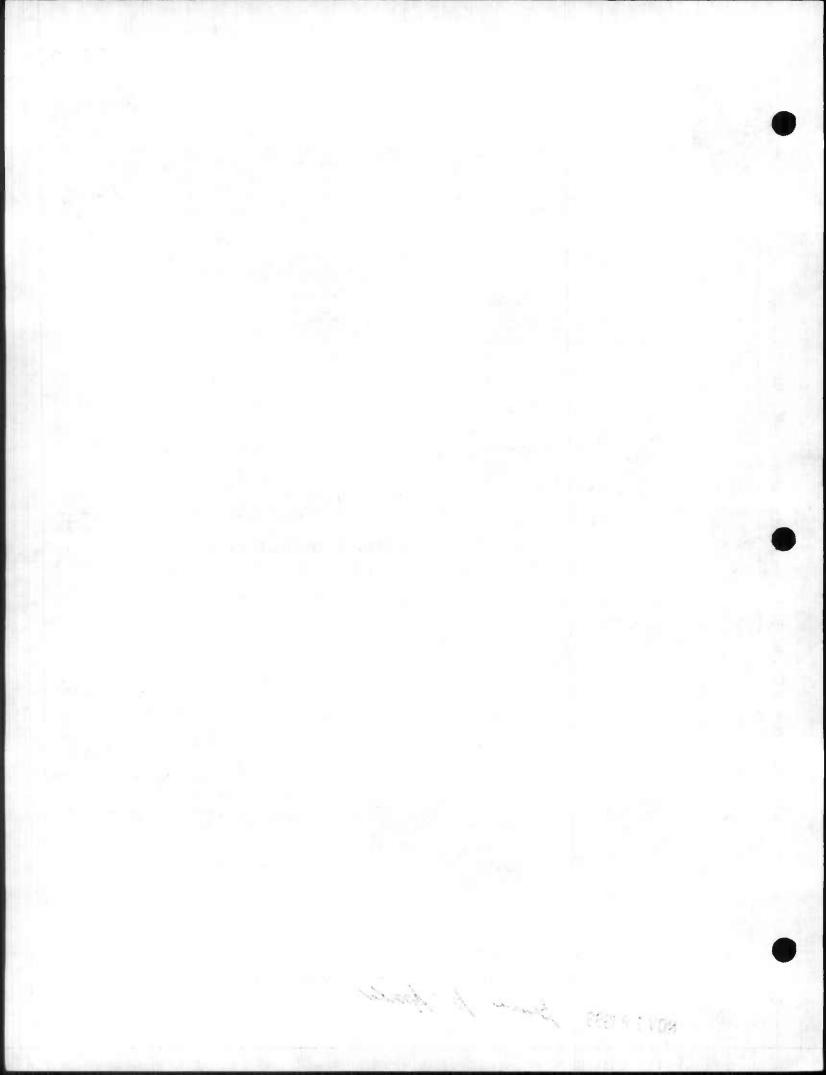


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State of Maryland / Department of Health and Mental Hygiene

36221. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Yee **Physician** ALOYSIUS WALSH NOVEMBER 14, 1999 7:12 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 27, 1917 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1 G-M 2□ F 213-03-6087 Yrs 82 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23s or 28s-f show the Madical Examinar must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 524 North Charles Street 21202 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1. Yes 2 □ No
If Yes, Give 14. Race - American Indian, Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Yeer or Detes: Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglena. Elementary/Secondary (0-12) College (1-4or 5+) UNK. UNK. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: If Item 27 is marked other any Injury or other treument. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Aloysius J. Walsh, Sr. Mary Hanley 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Eugene A. Walsh/nephew 13208 Constitutional Ave. Ocean City, MD 21842 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removal from Stete Metro Crematory, Inc. 11/16/99 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Poneral Service Ligensee 22. Name and Address of Eacility Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) SUSPECTED MYOCARDIAL INFARCTION /Medical < IWase Examiner Due to (or es e consequence of) Examine that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760. Physician/Medical the Due to (or as e consequence of): Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b by 24b. Were eutopsy findings evailable prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? 250 No 1 Yes 20 No certificata Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of tolony Clariffeth. Time of (Month, Gay Year) Injury 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending 14/99 n 24 hours after death.

• Funeral Director: A pletely filled in by the fi death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suiclde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Decrifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DO015452 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) TIMOTHY RESSENT, M.D., 7601 OŞLER DRIVE, TOWSON, MARYLAND 21204 32. Registrer's Sgneture 31. Dete filed (Month, Dey, Year) State NOV 1 8 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILLIAM 12:38 AM WELNOSKY, JR. NOVEMBER 14,1999 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VETERANS ADMINISTRATION HOSPITAL BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1♥M 2□ F Days Months Hours 212-44-8100 55 JULY 28,1944 Director MARYLAND Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 6701 WHITE WATER COURT #203 21060 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No 1961 – If Yes, Give Yeer or Dates: 1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. filled within 72 hours effer. Hyglene. ther then "naturel", or ite 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: P 3 ☐ Widowed ¾ ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed wit Depertment of Health end Mental Hygient Important: if tem 27 ie marked other than eny follury or other treumatic event, the 1 page. 12 PIPEFITTER CHEMICAL COMPANY 17 Father's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM A. WELNOSKY, SR. ETHEL SEWELL. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCOTT WELNOSKY - SON 2404 CHETWOOD CIRCLE, TIMONIUM, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State MARYLAND VETERANS CEMETERY11/18/99 CROWNSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE., S.W., GLEN BURNIE, MD 21061 190 gan 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) enatic encephalopath Examine Examiner The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician s s the buriel P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Records. p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed paga 2 a 1 ☐ Yes 2 No Division of Vital 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospitel: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 5 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affiler or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after deat Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 hb. Hospital 24 hours a 29a, Certifier 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 8 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 14, 1999

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print) N Greene street

Baltimore MD 21201

State Registrar

32. Registral's Signeture

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and soft woman characters are seen to the control of the control o	Greater Ba 5. Social Security Number 577-12-8804 Usual Residence of Decedent 10a. State 10b. Coun MD Bal 10e. Street end Number 13025 Manor R 11. Marital Status 1 Never Married Man 3 Widowed 4 Divorce (Specify only high Elementary/Secondery (0-12) 17. Father's Neme (First, Middle Robert Loui 19a. Informant's Name/Relation	altimore  6. Sex  WXM 2 F  tty  timore  12. Was Dece Armed For PC Service Gives Give	Medical 7. Age (In yrs. last b) 78  10c. City, Tov Long  dent Ever in U,S. ces? 20 No 6/42 etites: 6/46	vn or Location  Green  101. Zip Code 21057  13. Was Decedent of If Yes, specify Cu 1 Yes 2 XN  1. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	TOWSON ar Hunder 24 Hrs s Hours Min.  7-9628 Hispanic Orlgin? (Suban, Mexican, Puerlo o Specify: upatlon e during most of wored)	8. Date of Birth (Month, Dey, Ye December)  10g. Ur Specify Yes or Noto Rican, etc.)	Baltimes 9.8i 9.8i 16,1920 Citizen of What Conited States 14. Race - Am Black, Whi Specify: When the Specify: When the Specify: When the Specify: When the Specify: When the Specify: When the Specify: When the Specify: When the Specify: When the Specific S	ore thplace (State or Foreigounty)  Maryland  10d. Inside City Limits  1 Yes 2 No ountry?  Ites erican Indian, 1e, etc.	
and on whether they begin an article of the 23s or 28s-1 show are traumatic event, the Medical Exercises must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. Coun  MD  Bal  10e. Street end Number  13025 Manor R  11. Marital Status  1 Never Married  3 Widowed 4 Divorce  15. Decede (Specify only high property)  Elementary/Secondery (0-12)  17. Father's Neme (First, Middle Robert Loui  19a. Informant's Name/Relation	timore  oad  12. Was Dece Armed For Yorks, if Yes, Girly Yes, Grand or Danit's Education nest grade completed)  College (1. Armed For Year or Danit's Education nest grade completed)  College (1. Armed For Year or Danit's Education nest grade completed)  College (1. Armed For Year or Danit's Education nest grade completed)  College (1. Armed For Year or Danit's Education nest grade completed)	dent Ever in U,S. cos? cos? 6/42 e	vn or Location  Green  10f. Zip Code  21057  13. Was Decedent of If Yes, specify Cu  1 Yes 2 XN  1. Decedent's Usual Occ  (Give kind of work don life. DO NOT use retire)	7-9628  I Hispanic Orlgin? (Suban, Mexican, Puerlo  Specify:  upatlon  e during most of worded)	10g. Ur Specify Yes or No- lo Rican, etc.)	Citizen of What C nited Sta 14. Race - Am Black, Whi Specify: Wh	10d. Inside City Limit 1 □ Yes 2 N ountry? tes erican Indian, te, etc.	
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TEE				b. Malling Address (Stree 3025 Manor		ural Route Number, Ci Long Green ,			
Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: If Important: Impor	23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that ca	aused the death. Do	1050 York	Road To	owson, Mary	land 212	Home, Inc. 204 Approximate Interval Between Onset end Death	
edical iminer	Immediate Cause (Final disease or condition resulting in death)	SEP	Due to (or as a	tock consequence of):  DLE Aware consequence of):	1	1	EPAIK!	8 hours	
physician end s the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	S. ASPI	RATIO	S		E1C CO.	LIVEU	9 month	
for use existenting	resulting in death) Last	HEAD	AND NECK Sou	consequence of):  CRESECTI  AMOUS	ON FOR L	OANCER	MERAST	ATC.	
igned by the att	Part II. Other significent condit	tions contributing to dea	ath but not resulting I	n the underlying cause g	given in Part I.	23b. Did tobed	co use contribut	e to the cause of deat	
detaid						1 1/168	2 No 3 P	robably 4 Unkno	
should should						24a. Was an au performed		Were eutopsy findings eveilable prior to completion of cause of death?	
page 2						1 ☐ Yes	20 No	1 ☐ Yes 2 ☐ No	
certificate rector, pag	25. Was case referred to medic	al			26 Place of Dea	ath (Check only one)			
o b	examiner?	Hospital:	patient 2 ER/O	utpatient 3 DOA	Whoe	fome 5 ☐ Residence	6 □Other (Spe	ecify)	
5 2	27. Menner of Death  1 Natural 5 Pend 2 Accident inves	28a. Date of	f Injury 28b.	Time of 28c. Inj		28d. Describe how in		,	
intel Director: After the funeral by the funeral funeral Certification:	3 Suicide 6 Could	d not be mined 28e. Place of buildin	of Injury - At home, fag, etc. (Specify)	arm, street, factory, office	9	28f. Location (Street City or Town, St		tural Route Number,	
Fun stely	29a. Certifier	ing Phyaician: To the base in Examiner: On the base and manner	sis of examination ar	e, death occurred at the ad/or investigation, In my	time, date and plece opinion, death occu	, end due to the ceuse irred et the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
To the	29b. Signeture end title of certifit	ier Lang	mo	29c. Licer	nse number	29d.	Dete signed (Mon	th Dey, Year)	

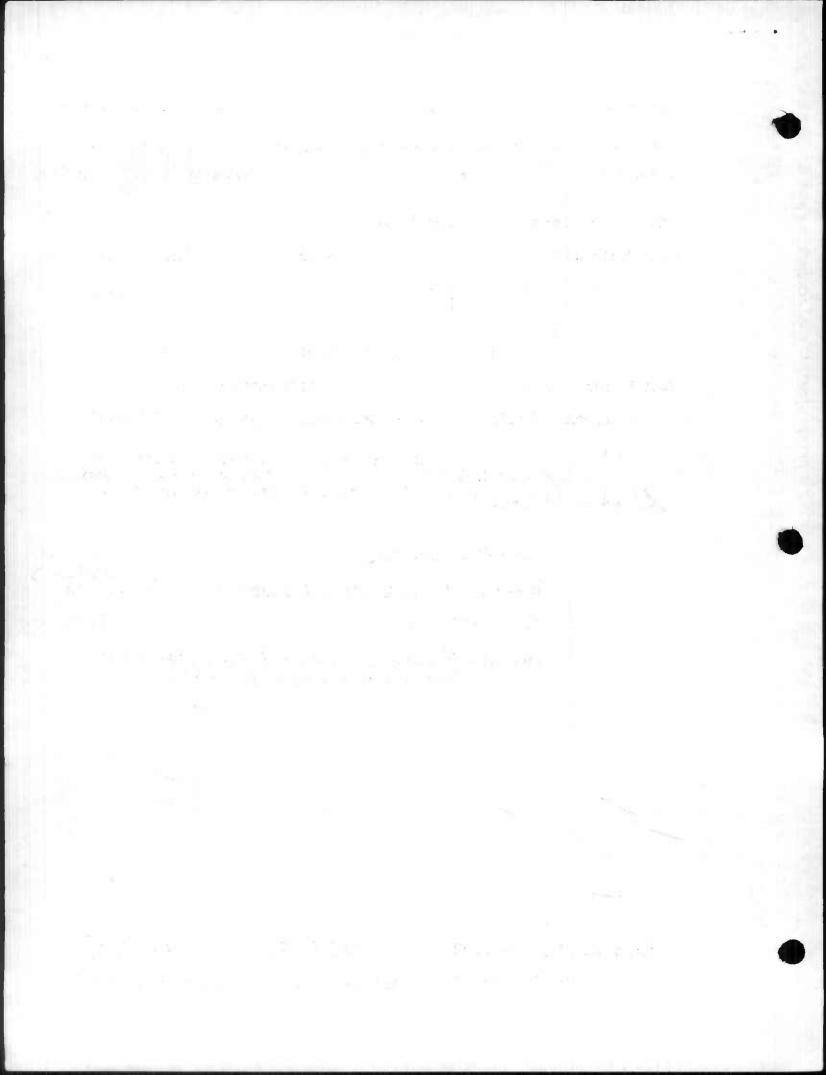
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

NOV 1 8 1999

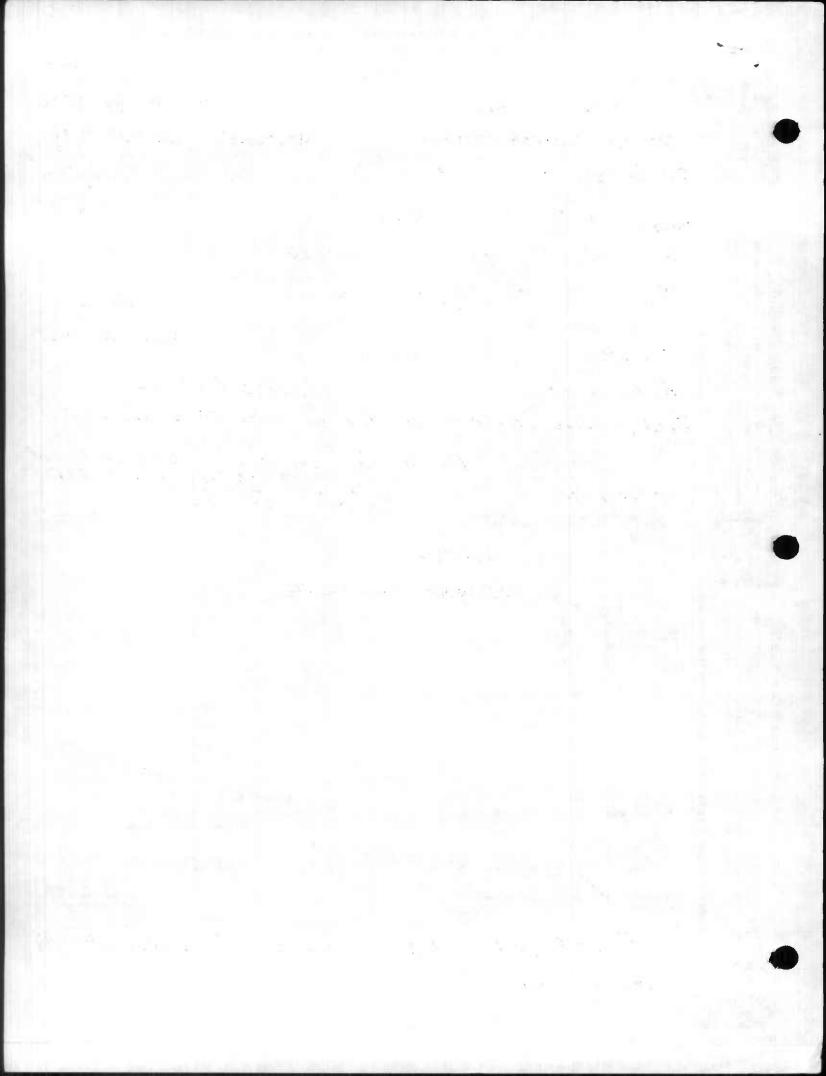
32. Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician 1532 ROBERT WHYE /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE VETERANS HOSPITAL BALTIMORE 6. Sex M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Deys Hours Min 219 42 984° Usual Residence of Decedent 54 Yrs. Director the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at BALLINGE Yes 2 No Director 4any sub 10650m 10f. Zip Code 10g. Citizen of What Country? Eudouoop LAME 21286 U512 292 2 should be filed within 72 hours after death ond Mental Hygiene.
Is marked other than "natural", or items 23. Funeral 14. Rece - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 Specify Black ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Print BUSINESS Elementery/Secondery (0,12) College (1-4or 5+) 10 # Grade 17. Father's Name (First, Middle, Last) LABOVER 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mc NOIL WHYE HARON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2/286 292 Evdowood Lane Town, Mary land 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health enc Important: If item 27 is n any injury or other traun GlAdys MUTHER W1448 292 altimore, 20b. Place of Disposition (Neme of cometery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State Owings mills, mel 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHA TOLOM- HOW'S
52 40 RCISTERSHOW KARD 21. Signature of Funeral Service Licensea Bles BAHANOTE, Red 2/2/5 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician Immediate Cause (Final disease or condition resulting in death) /Medical ACIDEMIA Examiner Due to (or as a consequence of): Examiner YSTEM ORGAN physician end the burief-trensit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or es e consequence of): 88 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 70 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Accident 5 Pending investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide Hospital 24 hours 29a. Certifier 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es steted. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier NOVEMBER 14th DO05486 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT F. CORDER 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

1/2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:10PM 1999 12 ROSA E. WHITE NOV /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILLENNIUM @ LIBERTY HEIGHTS NURSING CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1□ M 2🂢 F **Director** 170-20-7648 Usual Residence of Decedent with the Merylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Merylan Health and Mertal Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f ahow wither traumatic event, I'lls Medical Example manifed in the Medical Example. 1 ☑ Yes 2 ☐ No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Cifizen of Whet Country? 1617 EUTAW PLACE 21217 USA Funeral 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1□ Yes 2√ No Specify: BLACK Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -8-HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) RICHARD TONGUE OLIVIA TONGUE 19a. Informanf's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nit. Peges 1 end 2 sartment of Health e sortant; If item 27 is y Injury or other tre OLIVIA AYERS (NIECE) 1617 EUTAW PLACE BALTIMORE, MARYLAND 21217 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PARK 11-17-99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enfer the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) momhocy to ponia 1 month **Examiner** Due to (or es e consequence of): Examiner 1048 a nania physicien end the burial-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or as e consequence of): 1548 Damanh of Physician/Medical Due to (or as a consequence of): 88 USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy peen completion of cause of death? page 2 212 No 1 Yes 20 No 1 Yes certificete funerel director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After Attending 1 Natural 5 Pending efter death. 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streef, fectory, office building, etc. (Specify) 4 Homicide 9 Hospital 24 hours Funeral 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the Within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end fifle of certifier D 364994 15/90

AR

Balhman mo 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 1 8 1999

( DESALM 31. Date filed (Month, Day, Year)

4660 WILKI

32. Registrar's Signature

Registrar

Rosa white

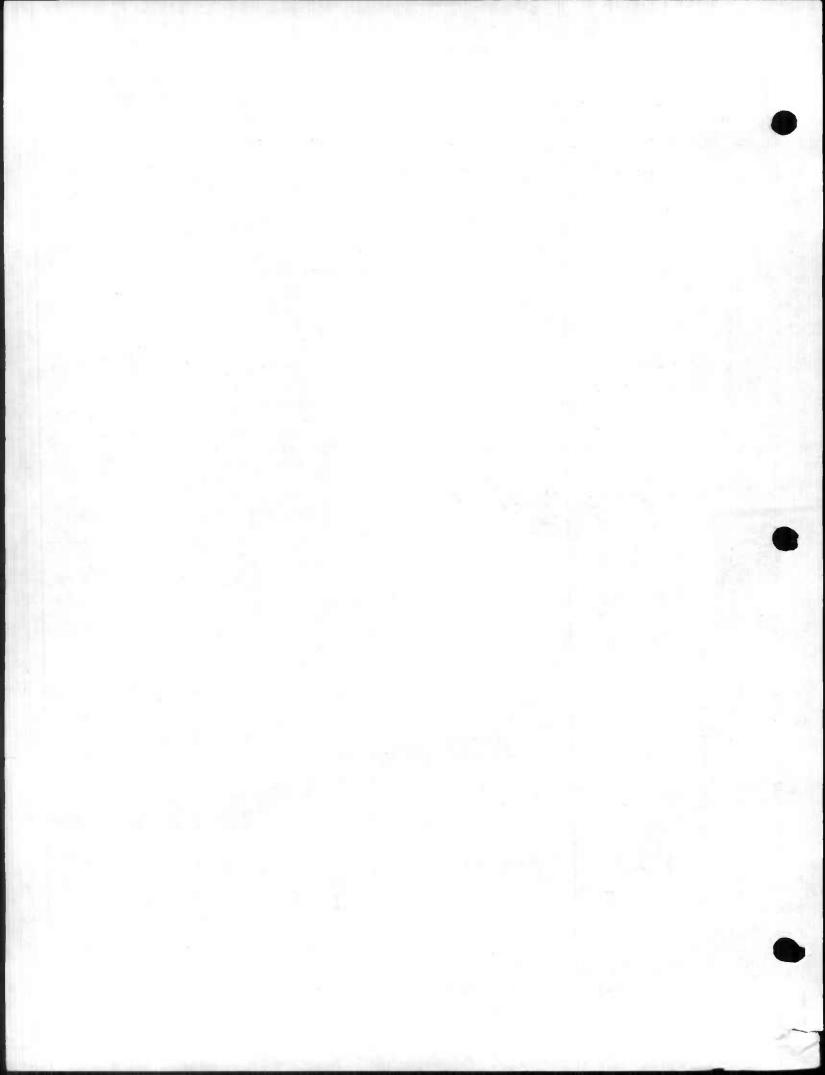
many of many sorting

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15,1999 Month **Physician** Jerome Joseph Zarachowicz NOVEMBER 07:01 A1 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT HOWARD MARYLAND HEALTH If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 15M 20 F Yrs Director Maryland 35-83 Usuel Residence of Decadent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD N/A Baltimore 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 4315 Springwood Avenue 21206 U.S.A. Itema 23a deeth v Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar In U,S. Armed Forcas? 14. Raca - American Indian. 11. Meritel Stetus Bleck, White, etc. filed within 72 hours efter 1 □Xas 2 □ No If Yes, Give Year or Detes: 1 Never Merried 2 Married 21215-0020 "naturel", or 1 ☐ Yas 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry i Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled wit Depertment of Health and Mentel Hygiens (mportant: if item 27 is marked other tha any injury or other treumatic event, that pace. Tool and Die Maker Steel Company Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Surneme) Be Edward Zarachowicz Cecelia Buczkowski 19a. Informent's Neme/Reletionship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Zarachowicz/Wife 4315 Springwood Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from Steta Holy Rosary Cemetery 11/18/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Addrass of Facility 21 Signature of Funeral Service Licenses John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23e. Pert1. Entar the disease or complications that fausad the daath. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart fautare. List only one ceuse of each line. Approximete Intervel Between Onset and Deeth **Physician** YEARS /Medical Immediate Cause (Final BRAIN TUMOR disease or condition resulting in death) Examiner Due to (or as e consequenca of): Examiner physicien and the burial-trensit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequança of): 950 ò P.O. signed by the a 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records. þ The law requiras should 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to Completed complation of causa page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital ai or Attending Physician: The state death.

I Director: After this certificated in by the funeral director, ps Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: Impatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Mennar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled in 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On tha basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier To the Fune edical (Check only one) To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatuje end title of certifier D14958 MMM NOVEMBER 15, 1999 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Rd Fort Howard, MD 21052 9600 North C. Tan. Point 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State NOV 18 Registrar **PHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dev Year Spencer G. 16, 1999 November 5:55 AM 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Death 4608 Eugene Avenue Baltimore N/A | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day Year) | Sept. 7, 1913 5. Sociel Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) North Carolina 552-14-3657 Yrs 86 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4608 Eugene Avenue 21206 S. A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2(X) Merried 1 XYes 2 No If Yes, Give Year or Detes: WW II 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 Years Elementery/Secondary (0-12) Captain Merchant Marine 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Spencer Garland Avent Sr. Bessie Thorne 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4608 Eugene Avenue, Baltimore, Maryland 21206 Mrs. Waltraud Avent (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 11/17/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signeture of Funeral Service Licensee mark 3331 Brehms Lane, Baltimore, Maryland 21213 23e. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Adenocarcinoma of un known Primary Origin 3 months diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 Yee 2 No 24b. Were autopsy findings eveilable prior to 24e. Was en eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Natural 5 Pending investigation

I or Attending Physician: The lew requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the bunal-trensit P.O. Box 68760. USB 85 been signed by the a should be detached Division of Vital Records, pege 2 funeral director,

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Physician/Medical Examiner

à

Completed

8

Medical Certification: To

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signeture end title of certifier

29a. Certifier

**Funeral** 

Director

the Meryland

Pages 1 and 2 should be filed within 72 hours after death with the Menylam nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Int: If farm 27 is marked other than "natural", or from a 23s or 28s-f show ury or other traumatic event, the Medical Engineer mast be notified as

permit. Pages 1 and 2 Department of Health s Important: If itsm 27 is any Injury or other tra

**Physician** /Medical

Examiner

3altimore, Maryland 21215-0020

filled in by 24 hours a Hospital

completely f To the To the To the F

State Registrar 31. Date filed (Month, Dey, Year)

NOV 1 9 1999

6 Could not be determined

fail MMPH

s of person who completed cause of deeth (Item 23a) (Type, Print) Vanderpool momph 32. Registrer's Signety

3400 Brehms Lane

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore MO

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month Year **Physician** THOMAS ANDERSON, SR. November 7:25 Pm 15 1999 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Agnes Healthcure NIA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 12 M 20 F Yrs. 219.30.0746 64 Director 01-06-Usual Residance of Decedent 10d. Inside/City Limits 10a Stete 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 No Director NA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA S. CULVER STREET 21229 Nerns 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Maritel Stetus 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No If Yas, Give 1 Yes 2 No Specify: naturel', or à 3 ☐ Widowed 4 ☐ Divorced BLACK Yaar or Dates Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 loopartment of Heelth and Mental Hygiene important: if Nem 27 is marked other than "natu any Injury or other treumatic event". 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry the Madical Elementary/Secondary (0-12) College (1-4or 5+) UNDER WRITER INSURANCE 12 TH GRADE NA 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be UNKNOWN MATTIE CHATMAN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) FRANCES ANDERSON WIFE 10 S. CULVER ST., BALTO. MO. 21229 20e. Method of Disposition 20b. Place of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 111-22-99 BALTO, MO 4 ☐ Donetion 5 ☐ Other (Specify) LOUDON PARK CEMETERY 22. Neme and Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 21. Signeture of Funeral Service Licensee oms 5151 BAUTO. NATL PIKE, BALTO. MO. 21229 23a. Pert1. Enter the bases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart in dre. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** Immediata Cause (Final disaesa or condition resulting in daath) /Medical Cartion Arrest Examiner Due to (or as a consequence of) Examiner oronory Artery di seuse Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Post aneurysm c. States arrhic repair Physician/Medical Dua to (or as a consequence of): 950 Part II. Other stantfloant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ⊠ Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes casa raterred to medical axaminer? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 1 Neturel 5 Panding 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

physician and the bunal-transit Box 68760 signed l Records, ANDERSON this Attending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A To the Fune completely fi

72 hours efter

21215-0020

State Registrar

29a. Certifier

(Check only one)

29b. Signeture end title of certifier

the mo

Department of Surgery Fraisi, Jr. 57. Agnes Houthicare
32. Registrer's Structure Sports 31. Data filad (Month, Dey, Year) NOV 1 9 1999

Resident

30. Neme end eddless of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) end mennar steted.

29c. License number

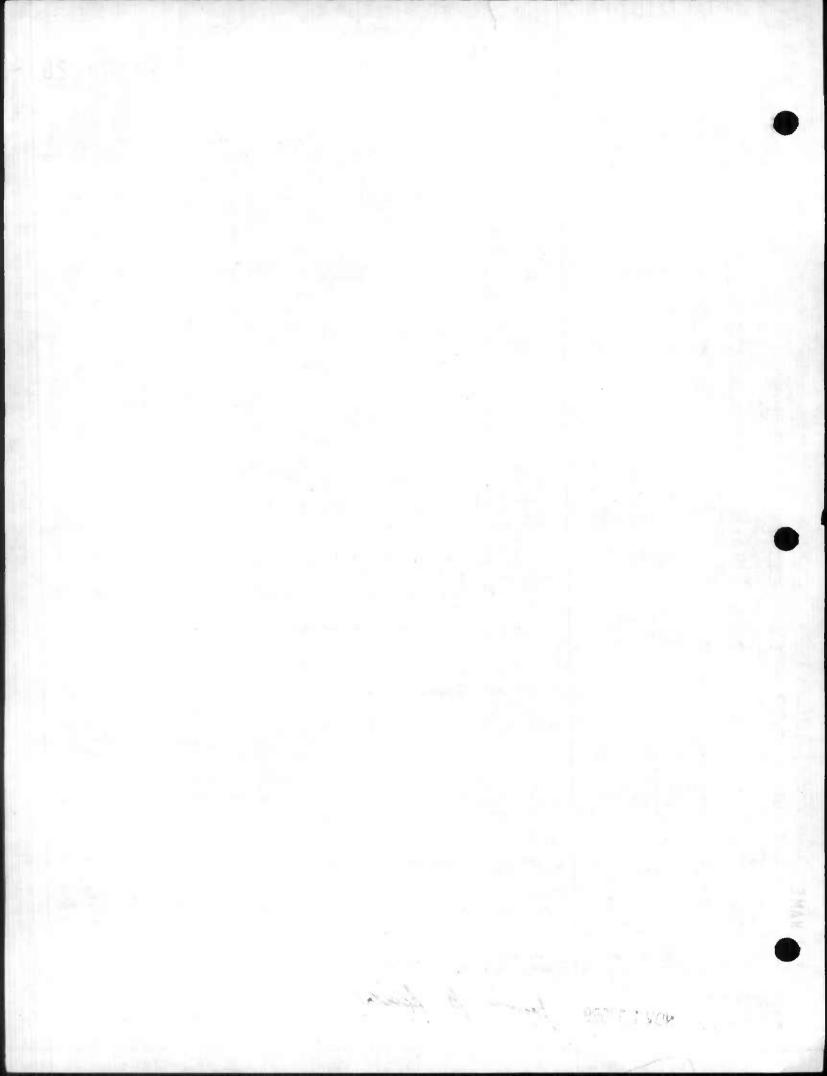
P10874

29d. Date signed (Month, Day, Year)

900 Cuton Ave

November 15, 1999

Bullimore, MO 21229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death BROWN Month 03.00 P **Physician** DOROTHY Nov. 17 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BONSECOURS MOSPITAL BALTIMORE CITY N/A If Under 1 Year 8. Data of Birth (Month, Dey, Year) NOV 5 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplaca (Stete or Foreign **Funeral** Months Days 1□ M 2\\ Hours VIRGINIA Yrs 84 Director 212-22-8837 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pagetiment of Health and Mental Hygiens. Hygiens frostures, or Herne 23s or 28e-f show important: if Hem 27 is marked other than "natures", or Herne 23s or 28e-f show shy Injury other traumatic event, the Medical Examinator must be notified at 1XXYes 2 □ No BALTIMORE CITY Directo MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21220 3 BEECH DRIVE APT F Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ XNo
If Yes, Give
Year or Detes: 1 Never Married 2 Narried Baitimore, Maryland 21215-0020 1 Yes ZXNo Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA WORKER FOOD SERVICE 8th grade 17 Father's Nama (First Middle Last) 18 Mother's Name (First, Middle, Maiden Sumeme) 88 0 unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3 Beech Drive Apt F., Baltimore, Maryland 21220 Joyce M. Sheppard/Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Devirial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 11 - 24BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 21. Signature of Funeral Service Licensee ruows 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NEUMONIA Examiner Due to (or as a consequence of): Examiner SEPSIS physician and the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. edicai Due to (or as a consequence of): Physician/M signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Deen The lew certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this cardifor completely filled in by the funeral director, i 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? Certification: 28b. Time of 1 (SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide dicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier NOV: 17 16 1999 Vasanthalauma D42510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VASANTHA COM AN 821 N. EUTAWST SUITE 407 MD 21201

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

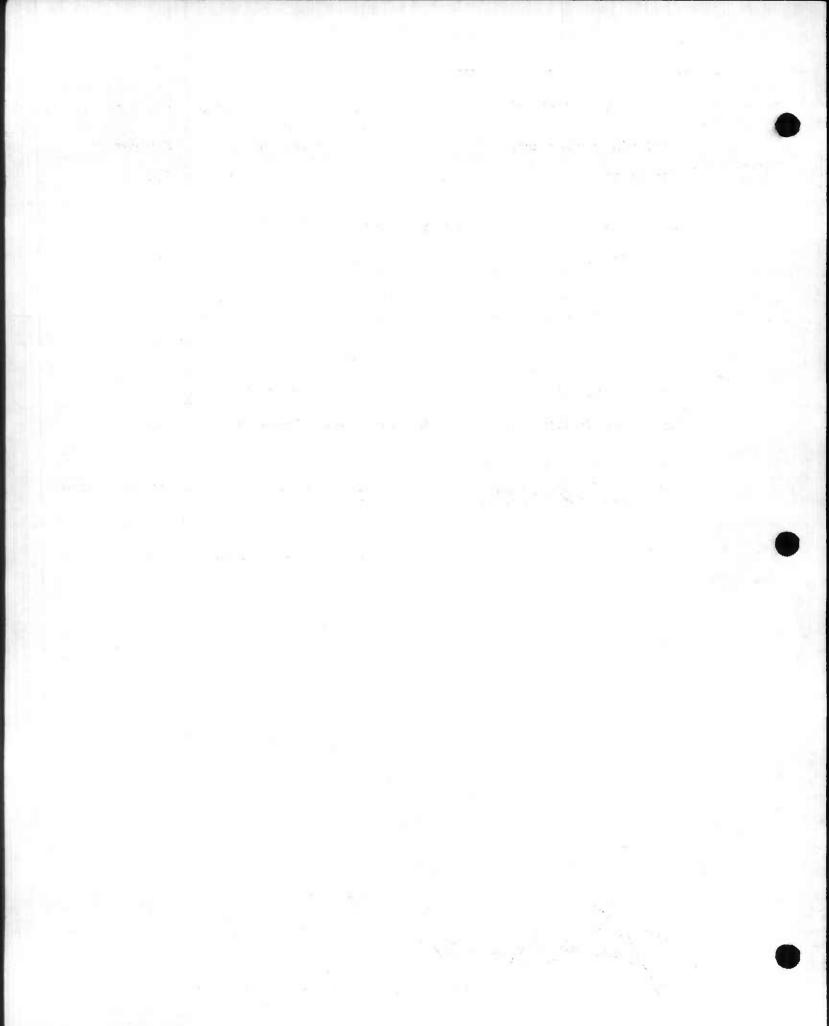
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Physician	1. Decedent's Neme (					ificate of		2. Date of De		Yeer	3. Time of Death	
/Medical	GERTRUDE LEVINA BEALE  Month November 15, 19  4e Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death 4c. County of Death									8:15 a.m		
Examiner								Location of Deat				
	Sunbridge 5. Social Security Num		7.40	a the constant	st birthday)	If Under 1 Year	Elkton If Under 24 Hrs	Date of Di-	Ceci		10 5 :	
uneral rector	215-28-611 Usuel Residence of De	8 10	M 200 F 92		Yrs.	Months Days	Hours Min	. (Month, Da	20, 1907	Mari	ece (Stete or Foreigi ry) YLand	
ahow Mail		0b. County		10c. City,	Town or Loca	ation				10	d. Inside City Limits	
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by Funeral	11. Marital Status 1 □ Never Merried 3 ☒ Widowed 4 [	2 Married	12. Wes Decedent I Armed Forces? 1 ☐ Yes 2 ☒ I If Yes, Give Year or Detes:			es Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	e - America ek, White, e	itc.	
Completed	(Specify Elementary/Second 4th grade	5. Decedent's Educionly highest grade ery (0-12)	cation completed) College (1-4or 5	i+)	16a. Decedent's Usuel Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Homemaker					of Business/Industry  Home		
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To Be	George Edu	oard Myer	S				Floren	ce Virai	ce Virginia Howard			
-	19a. Informent's Name				19b. Mailing	Address (Street		ural Route Numb			Code)	
	Eva E. Hyn	res (Daua	hter)			hoice S		Bel Air		1014		
	20e. Method of Dispos	ition		20b. Ple		tion (Name of tory or other plea		Dete	20c. Location -		vn, State	
	1 X Burial 2 C	Cremetion 3 DR	emovel from State					1/17/99	Elhaid	100 1	lanuland	
and and and and and and and and and and	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility						ss of Fecility	el Home of Bel Air, Inc.				
	23a. Pert1. Enter the shock, or heert for	disease or compli			Do not optor	O W. Mai	cPhail R	oad, Be	l Air, 1	ND 2	1014 Approximete	
fedical Examiner	Sequentially list condi- if any, leeding to imme cause. Enter Underly Cause (Disease or injuitat initiated events resulting in death) Las	tions, ediate ing		Due to (or o	es e conseque es e conseque	ence of):					YEARS	
3		d								- 1		
an	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										the cause of death	
rsician	Part II. Other significa	nt conditions con	tributing to death bu	it not result	ing In the und	erlying cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to		
by Physician/M						lertying cause giv	en in Part I.		Yes 20 No		ably 4 Unknow	
by	Part II. Other significa  CORONA:  PAR CI					lerfying cause giv	en in Part I.	1 🗆 24a. Wes	1.4	3 Prob	ably 4 Unknown re eutopsy lindings illable prior to npletion of cause leeth?	
by						lerlying cause giv	en in Part I.	1 🗆 24a. Wes	Yes 21 No en autopsy emed?	3 Prob	re eutopsy findings ilable prior to appletion of cause	
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Be Completed by	CORONA.	NOMA		SEAS		erlying cause giv	26. Place of De	1 □  24a. Wes perfo	Yes 200No en autopsy med?  Yes 200No one)	24b. We eve cor of c	re eutopsy lindings ilable prior to npletion of cause leeth?	
To Be Completed by	25. Was case referred examiner?  1 Yes 2 No  27. Menner of Death 1 Neturel 2 Accident	RY AR7	OF CL	SEAS	E	3□ DOA Oth	26. Place of De	24a. Wes perfect	Yes 200No en autopsy med?  Yes 200No one)	24b. We eve cor of c	re eutopsy lindings ilable prior to npletion of cause leeth?	
To Be Completed by	25. Was case referred examiner?  1 Yes 2 No  27. Menner of Death  1 Neturel  2 Accident  3 Suicide  4 Homicide	RY AR7  NOM A  Ito medical H  S Pending investigation Could not be determined	ospitel:    Description   Description	o LO M	R/Outpatient 28b. Time of Injury	3 DOA Oth 28c. Injur Wor M 1 1	26. Place of De er: 4 Nursing l y at k? Yes 2 □ No	24a. Wes performent of the control o	en autopsymmed?  Yes 2 No one)  dence 6 Oth how injury occur  Street and Number, Stete)	3 Prob  24b. We eve cor of c  1 L  er (Specify red	re eutopsy lindings ilable prior to ropletion of cause leeth?  Yes 2 No	
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_	Amen	ded	Items#23a,24a,25,26,27	,29 perPhyG7	77 11/19/ <b>9</b> 6	ertificate of	Death		Reg. No.	36231	
	Physic /Medi		Decedant's Nama (First, Middle, La.     MARY B. BIF	•				2. Data of De Month October	Day	Year 1999 8:30 am	
$\rangle$	Exami		4a. Fecility Nema (If not institution, give		4b. City, Town, or Location of Death 4c. County of Death						
			Friends Nursing	home			Sandy Sp:	ring	Mont	gomery	
	Funeral Director		5. Social Security Number 6. S  009-01-9782  Usuel Rasidance of Decedant	ex 7. Age □M 2√2 F	9 (In yrs. last birthday 85 Yrs.	Months Days	If Under 24 Hrs.	8. Data of Bir (Month, Da July 24	th y, Year)	Birthplaca (Stata or Foreign Country)     MD	
	death with the Merylend ms 23a or 28a-f show f must be notified at	2	10a. Stata 10b. County		10c. City, Town or L	ocation	· · · · · · · · · · · · · · · · · · ·			10d. Insida City Limits 1 ☐ Yas 2€ No	
	M ed M	ctc	MD Montgome	ry	Sandy Sp						
	vith t	Director	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhat Country?	
	s 23s or	Fai	17401 Norwood Ro			20860			U.S.A		
020	ja 22	by Funerai	11. Marital Status  1 ☑ Navar Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedent E Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas:		Was Decedent of I If Yas, specify Cub 1 ☐ Yas 2 ☑ No	Hispenic Origin? (Span, Maxican, Puart Specify:	pacify Yas or No o Rican, etc.)	Blac	e-Amarican Indian, k, Whita, atc. White	
Maryland 21215-0020		Completed	15. Decedant's Ec (Specify only highast gra Elemantary/Secondary (0-12)	+) (Give	16a. Decedant's Usual Occupation (Giva kind of work dona during most of workin, life. DO NOT usa retired)			16b. Kind of Businass/Industry Medical			
7	Hygi ther nt,		12 17. Fathar's Nama (First, Middle, Last)	5+	Occupational Therapis			C na <i>(First, Middl</i> a,	۹۱		
an	od be	Be c						2003 000		9/	
7	d Me	P	Lennox Birckhead  19a. informent's Neme/Ralationship (	Time Point	40h Mail	ing Address (Ctros	Mary Bud			Charles The Condition	
Ma	d2 s th en 7 is r		Taylor Brickhead/				ad, Balti			Stata, Zip Coda)	
Ġ,	Heall Heall ther		20a. Mathod of Disposition	brother	20b. Place of Disp		id, Dalti	Date Date		City or Town, Stete	
Baltimore,	thent of the		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	1	cematary, cre	matory or othar pla					
Bal	Depending the poor of the poor		21. Signature of Funeral Service Licen Ronald	S/ Woden	ed, 655 W. Baltimore Street,						
	Physician		23a. Part 1. Entar tha disaase, or comp shock, or heart failura. List only	olications thet caused ona causa on aach lin	the death. Do not er a.	ntar tha mode of dy	ing, such es cardiac	or raspiretory e	rrest,	Approximate interval Batween Onsat and Death	
E	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)		inical <del>C.V</del>		ovascular A	ccident		Acute	
0,	ificate be executed physician end as the buriel-transit	√Medicai Examiner	Sequentielly list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaase or injury that initieted evants	U	lti Infarc Dua to (or as a consa		ia			5 years	
Box 68760,	ding		Cause (Disease or injury thet initieted evants rasulting in death) Lest	d							
Ď	death e etten ed for u	cia	Port II. Other elemitions acceptance	maidh ata a sa da ata t	ng to death but not resulting in the underlying cause given in Part I.						
O.	the the	/ Physician/M	Pert II. Other significant conditions of	ontributing to death bu	uting to datan but not rasulting in tha undarrying cause given in Part I.				b. Did tobacco use contribute to the cause of death  1   Yes 2   No 3   Probably 4   Unknow		
Records,	iew requires thet es been signed b 2 should be dete	Completed by						24a. Was perfo	an autopsy rmed?	24b. Ware autopsy findings available prior to completion of cause of daath?	
Œ	The is	PO						10	Yas 2 No	1 ☐ Yas 2 ☐ No	
Viita	ysician: The lev is certificate hes director, page 2	Be	25. Was casa rafarrad to medicai				28. Piace of Das	th (Check only o	ona)		
of <	S o D	10	axaminar? 1 ☐ Yas 2∭ No	Hospitel: 1 Inpatiar	nt 2 ER/Outpetie	ont 3 DOA Ot	har: 4 🖄 Nursing H	oma 5 Rasi	dance 6 Oth	ar (Specify)	
	Attending Ph ir death. ector: After th by the funeral		27. Mannar of Daath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accidant invastigation	28a. Data of Injury (Month, Day Year)  28b. Tima of Injury  Work?  M 1 Yas 2 No				28d. Dascribe how injury occurred			
	마하는	Certification:	3 ☐ Suicide 6 ☐ Could not be datarminad	28e. Place of Inju building, atc	ry - At homa, farm, s (Specify)	treet, factory, offica		28f. Location (: City or Tou	Straat and Numb vn, Stata)	er or Rural Route Number,	
	To the Hospital within 24 hours e To the Funeral C completely filled	edicai	29a. Cartifiar (Check only 2 Medical Exam	/sician: To the bast of linar: On the basis of and mannar stat	examinetion end/or in	th occurred at tha ti nvastigation, in my	ma, data and piace opinion, daath occu	, and due to the rred at the tima,	cause(s) and ma data and placa, a	nner as stated. and due to the cause(s)	
	within 2 To the comple	×	29b. Signalere aptivitie of certifier	mn	1.1	29c. Licens	sa number		29d. Data signed	d (Month, Day, Year)	
			30. Nama and addrass of person who of	Control cause of the	MIN (Itam 23e) (Tunn	D14	568		Oct.	19, 1999	
			Thomas E. Dooley	, M.D. 179	904 Georgi		Olney,	Marylan	d 20832		
	Sta Registr		31. Data filed (Month, Day, Year)	32. Registra	r's Signatura	4 Spa	· Kai				



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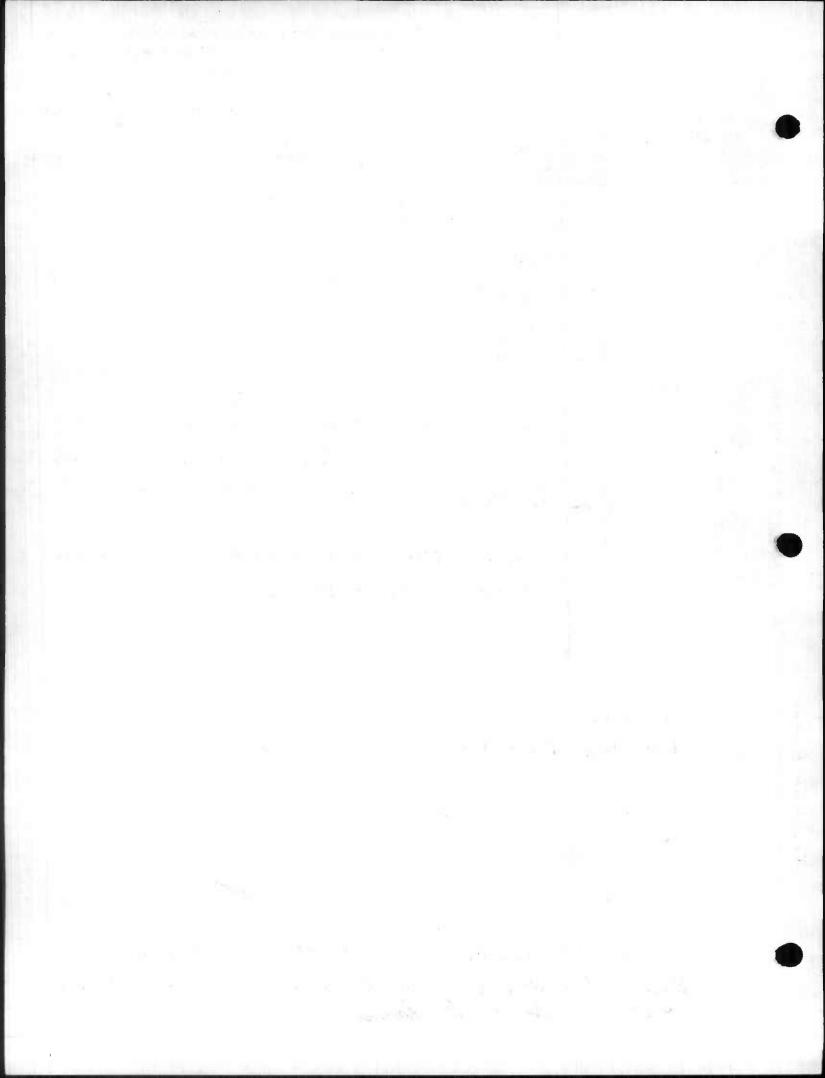
State of Maryland / Department of Health and Mental Hygiene

36232 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month FRANKLIN BUTLER NOVEMBER 1999 00:48A /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner SAINT AGNES HOSPITAL BALTIMORE NIA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 12 M 2□ F Hours 217-34. 2305 Yrs. 59 Director mo Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director NIA BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21229 4016 WOODRIDGE ROAD USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours aftar to Department of Health end Mental Hyglene. Important: If ferm 27 is marked other than "natural", or feel may injury or other traumatic evant, the Medical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1□ Yes 2☑ No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottege (1-4or 5+) DRIVER DISPOSAL 10 TH GRADE MA Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES DOVE MARY COLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY BUTLER BALTO. MO. 21229 4016 WOODRIDGE ROAD, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 11-20-99 RANDAUSTOWN, MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREEUE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MO. 21229

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such es cerdiac or respiratory arrest, shock, or heart-enture. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In deeth) Myounder Examiner Examiner angestive for use as the burial-transit or Attanding Physician: The law requires thet the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Stage Renal Disease After this certificate 1 ☐ Yes 2 X No 25. Was case referred to medicat 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Naturat 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fi deeth. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51853 Physician November 17, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD
32', Registrar's Signature Baltmore 21227 Silvermon 900 Caton Avenue filed (Month, Day, Year) State Registrar

**DHMH 16 Rev 6/95** 

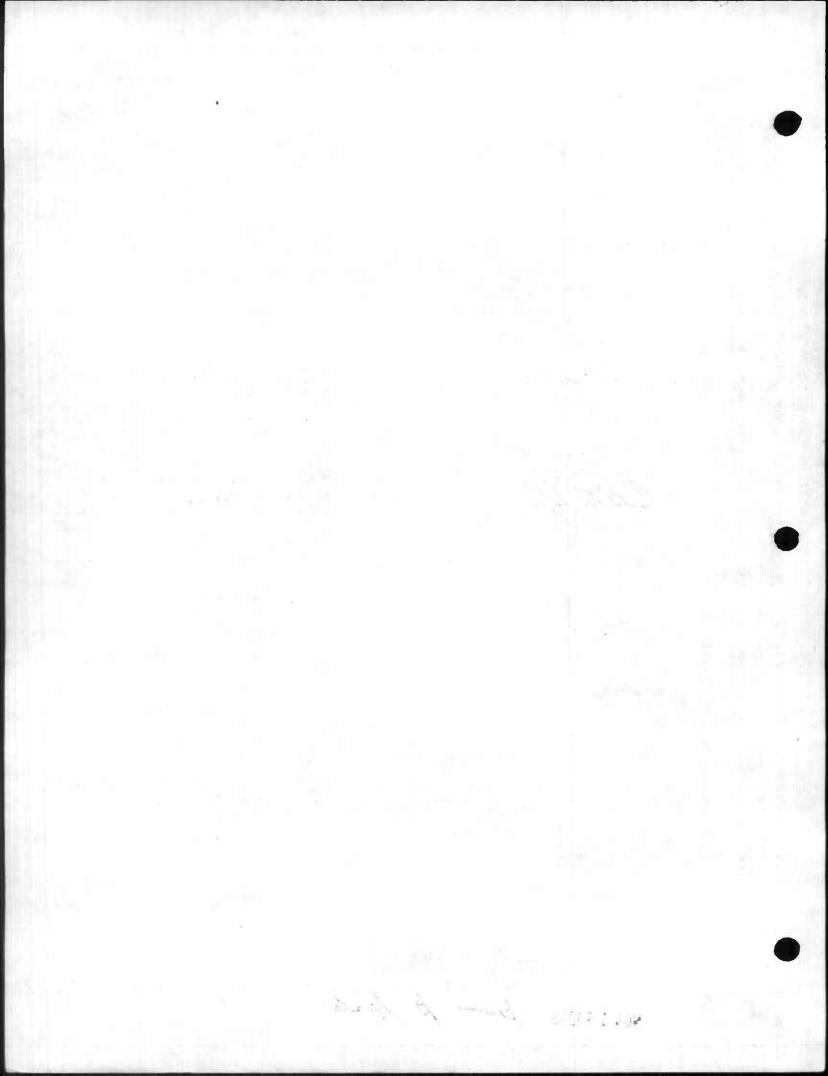
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q 36233 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Bess M. Bucci November 8:15 P.M. /Medical 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner RosedAle SQUARE BAITIMORE TRAUKlin HospilAl Ter Cen If Under If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 1/2/1919 9. Birthplece (Stete or Foreign Country) Maryland Age (In yrs. last birthday) **Funeral** Days 212-01-4313 1 M 2 3/F 80 Months Hours Director Usual Residence of Decedent with the Manylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 8810 Walther Blvd. Apt 1222 21234 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ②XNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Black, Whita, atc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 end 2 should be filed within Department of Health and Mentel Hygiene. Important: If item 27 is marked other than \*! Elamentary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumerne) Be Giavanna DeBona Pasquale Pellegrini 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Irid Naver/Daughter 2 Valley Wood Ct. Timonium, Maryland 21093 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 11/16/99 Baltimore, Maryland Holy Redeemer Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Facility 21. Signature of Funeral Service License Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition rasulting in death) Examiner Examiner physicien and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, by been sig 24b. Wara autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 1 Yes 2 LINE 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physicien: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient Certification: To 1 Yes 2 HNO 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Naturel 5 Pending death. 1 ☐ Yas 2 ☐ No Investigation 2 Accident Director: / 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Directompletely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end titla of com 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddr who completed cause of death (Item 23a) (Type, Print) Franklin Square Dr. Ste 312. 9105 monton 32 Registrer's Signeture 31. Dete filed (Month, Day, Year) State Registrar NOV 1 9 1999

C DHMI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Liveth MOVEMBER 18th PA OROTHER 1.30am 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SAMARITAN HOSP OF MARYLAND. BALTINURE 4000 BALTIMORE 8. Dete of Birth (Month, Day, Year) Jan. 20,1911 5. Social Sacurity Number If Under 1 Yeer Months Days if Undar 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months 1 M XXF Hours 88 214-40-5504 Maryland Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore County Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 7525 Belair Rd. 21236 USA 12. Wes Decedant Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Nevar Married 2 Married 1 Yes XX No If Yes, Give Yeer or Dates: 1□ Yes XX No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Balto. City Dept. Elementary/Secondary (0-12) College (1-4or 5+) of Recreation N/A 12 yrs. Director 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) George E. Bartens Mary T. Connors 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Straat end Number or Rurel Routa Number, City or Town, State, Zip Code) Gerard V. Caldwell 7701 Belair Rd. Baltimore, Md. 21236 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State Data XIX Burial 2 Cremetion 3 Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 11-19-1999 Baltimore, Md. 22. Name and Address of Facility LASSAHN FUNERAL HOME 21. Signature of Funerel Service Licenses 7401 BELAIR RD. BALTIMORE, MD. 21236 23a. P. M. Enter the disease, or complications thet causad the death. Do not antar tha mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one cause of each line. PHEUMONIA Immediate Ceuse (Final disease or condition resulting in deeth) UROSEPSIS Due to (or es e consequence of): ARTHEROSCLEROTIC CARDIOVASCULAR DISTAGE LEIMERS DISEASE Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

buriel-trensit

the

Be Completed

Medical Certification: To

and

ettending physician

P.O. Box 68760.

Records,

Division of Vital

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If flow 27 is marked other than "natural", or frems 23s any injury or other traumatic avant.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last Physician/Medical

HYPOTHYROTDISM

MONE INSULIA DEPENDENT DIABETES MECLITUS

1 Dinpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28b. Time of 1 Maturel

5 Pending investigation 2 Accident 3 Suicida 6 Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29e. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and menner stated.

29b, Signature and title of certifier

31. Dete tiled (Month, Day, Year)

29c. License number

29d. Date signed (Month, Dey, Year) Morenber 16th 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) BERTHA

5601 LOCH RAVEN BZVD AYI, GOOD SAMARETAN HOSP OF MARYLAND, BALTIMORE, MD 2/239

State Registrar





**DHMH 16 Rev 6/95** 

To the Hospital or Attending Physician: within 24 hours effer death.

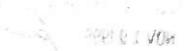
To the Funeral Director: Affer this certifica completely filled in by the funeral director, I

328 R F VOM

### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36235

	Certificate of D	eath Reg. No.							
Dhuaisia	1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaer 3. Time of Death							
Physician Medica	MIGHEL BERKOVSKY	11 18 99 2240							
Examiner		City, Town, or Location of Daeth 4c. County of Death							
	Mercy Medical Center	Baltomere N/A							
Funeral Director	056 415 0217-3 1X M 2 F 84 Yrs. Months Days	If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) MAR . 10 , 1915 RUSSIA							
bud *	Usual Rasidanca of Decedant  10a. Stata 10b. County 10c. City, Town or Location	10d. Insida City Limits							
the Maryland 28a-f show	MEXICO VERACRUZ CORDOBA	1X Yes 2 □ No							
firer deeth with the Ma ritems 23s or 28s-1s river must be notified		10g. Citizen of Whet Country?  MEXICO							
Urs e urs e	1 Nevar Married 2 Merried 1 Tyas 2 No	panic Origin? (Specify Yes or No- Maxican, Puarto Rican, etc.)  Specify:  14. Raca - Amarican Indian, Black, Whita, atc.  Specify:  WHITE							
15-002 n 72 hours "natural", edical Exe	15. Decedent's Education 16e. Decedent's Usual Occupati (Specify only highest grade complated) (Give kind of work dona du	ion 16b. Kind of Business/Industry							
nd 21215-0020 si filed within 72 hours et al hygiene. other than "natural", or rem, the Medical Evann	Elementery/Secondery (0-12)  12  College (1-4or 5+)  ADMINISTRATOR	SUGAR FACTORY							
be filed tal Hygid d other event, I		8. Mother's Nama (First, Middle, Meiden Sumame)							
should be and Mantal marked o imatic eve	ISAAC BERKOVSKY	TAIBA KAGANOVICH							
Maryland nd 2 should be file nuth and Mantal Hy 27 Is marked oth r traumatic event		nd Numbar or Rurel Routa Numbar, City or Town, Steta, Zip Code)  CORDOBA, VERACRUZ, MEXICO 94580							
5 8 7 = P	20a. Mathod of Disposition  1 Burial 2 Cramation 3 Ramoval from Stata								
Baltim permit. Pa Departmen Important: any Injury once.	4 □ Donation 5 □ Othar (Specify) OUT OF COUNTRY PANTEON ISRAI  21. Signatura of ∮unaral Sarvica Licansen 1 22. Nama and Addrass	of Facility							
Balt permit. Depart Importa	1 - FIII	SOL LEVINSON & BROS., INC.							
	23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, shock or haart failura. List only one cause on each line.	ERSTOWN ROAD - PIKESVILLE, MD 21208 such as cardiac or raspiretory errast, Approximate Interval Batween							
Physician	shock or haart failura. List only ona causa on each line.	Intarval Batween Onsat and Daath							
/Medical	Immediate Cause (Final disass or condition	100 min							
Examiner	disease or condition resulting in deeth)  a. Mes evier( Iso  Due to (or es e consequence of):	nerma adags.							
by exacuted in and inal-transit	ATVICE FIBRICATION	9 years							
58760, icate be executed physician and site bunal-transit	Sequentially list conditions,  flavy leading to immediate  But to (or as a consequence of):								
68760, rificate be exect on physician and as the buniel-tr	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
68760, ificate be experience of physician as the buna									
certific	d								
death cert death cert e e ettendin e d for use	Death Other death and an all the second at t	n in Part I. 23b. Did tobacco use contribute to the cause of death?							
0 4 4 5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	1 Yes 2 No 3 Probably 4 Unknown							
	History Cerebral Vasilar Accident								
Peer shou		24a. Was an autopsy performad?  24b. Wera autopsy findings evailable prior to completion of cause of death?							
The law ata hes page 2		1 Yas 2 No 1 Yes 2 No							
Vital Insident The cartificate irector, page Co.	25. Was case starrad to medical examiner?	26. Place of Daath (Check only one)							
Of Vita Physician: this cartificant director.	1 2 vas 2 No Hospital: 1 Inpatiant 2 DEN/Outpatient 3 DOA Other	4 Nursing Homa 5 Rasidence 6 Othar (Specify)							
ding Pi h. After th funera	27. Manner of Death 28e. Date of Injury 1 □ Natural 5 □ Pending 28e. Date of Injury (Month, Dey Year) 28b. Time of linjury Work?								
Attending ridesth. ector: After fune by the fune	2 Accident invastigation M 1 Yo	es 2 No							
Division of tall or Attending P rs after deeth. al Director: After ted in by the funer.	4 Homicida  detarmined  detarmined  28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)							
Hospi 14 hou Funer taly fil	29a. Cartifiar  1 Cartifying Physician: To the bast of my knowledge, death occurred at the time (Check only Medical Examiner: On the basis of examination and/or investigation, in my opin								
within 2 To the comple	one) and mannar stated.  29b. Signature and the of sertifier 29c. Licanse	number 29d. Dete signed (Month, Day, Year)							
5.¥5.8	b V. Mallan	ON 4016 White							
	ATTENDING Physican	0 101601118199							
	30. Name and address of person who complated causa of daath (Item 23a) (Type, Print)  Scott J. Mcheson MD								
State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	9 ;							
	MANY & MADON A PROMETER PO MADELLE								



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and the suggest

WRC 99-6904-510 ROBERT COL

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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death	Reg. No.	99	3623
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1999

11:01 PM.

Birthplaca (Stata or Foreign Country)

White

10d. Inside City Limits 1 ☐ Yas 2 XNo

Approximata Interval Between Onset and Death

24b. Ware autopsy findings evailable prior to completion of cause of death?

12 Yas 2□ No

E	SF	2	
	H	Physic /Medi Examii	ca
		uneral irector	
	anyland	show d.m.	

1. Decedent's Nama (First, Middla, Last)

NOVEMBER 17, Robert Meredith Cole, Sr. 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth SHOCK TRAUMA BALTIMORE n/a If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 1 M 2 F Months Days Hours 219-28-0888 68 March 28,1931 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location Directo 28e-f Baltimore White Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ma 23a or 18101 School House Rd. 21161 USA Funeral 12. Was Decedent Evar in U,S.
Amyed Forcas?

1 X Yes 2 □ No
If Yas, Giva
Yaar or Datas: 156-159 r than "natural", or frame the Medical Examiner on Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filad within 72 hours after 1 Nevar Married & Married 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiena. Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 n/a Truck Driver Transportation aitimore, Maryland 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) . Pagas 1 and 2 should be fill transford Haalth and Mental Hant: If Item 27 is marked off jury or other traumatic even Be Samuel Parkin Cole Ann Elizabeth Thacker 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lois Cole/wife 18101 School House Rd, White Hall, MD 21161 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata cematary, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: If eny injury or pace. 4 ☐ Donation 5 ☐ Othar (Specify) Balto, Wash, Crematory 11/22/99 Laurel, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Lemmon Funeral Home Michael J. Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in daath) gunshot wound Examiner Dua to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 88 USB been signed by the s should be dateched Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dfd tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yes 2 No Records, þ Completed 24a. Was an autopsy page 2 1X Yes 2 □ No cartificata Division of Vital or Attending Physician: funeral director, 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To NOXYas 2 No this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After Injury 1 Natural 5 Pending e Hospital or Attendin n 24 hours efter death. e Funeral Director: Aft 1 Yas 2 No Subject Shet Self

281. Location (Street and Number or Rural Route Number, Read
City or Town, State) 18 101 School House Read invastigation 2 Accidant 11-17-99 untrown 3 Suicide 4 ☐ Homicida 6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by Yand of residence Baltimore County, Manyland

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2▼ Medical Examiner: On the besis of aximination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Yard 29a. Cartifiar Medical (Check only one) completely and mannar stated. within 2 To the ŝ 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 0 O.C.M.E. NOVEMBER 18, 1999 170 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Stephen 5.
31. Data filed (Month, Day, Year) 5. Radentz,

DHMH 16 Rev 6/95

State Registrar 32. Registrer's Signetura

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State of Marylar	d / Department	of Health and M	lental Hygiene

υπ ζ 3 , ζ	7-28F PER M.E.O. G7  1. Decedent's Nama (First, Mid		U.A.	Cer	tificate of	Death	2. Date of D			5237 Tima of Death		
sician		Month	Day	Year								
ledical aminer	Aaron 4a Facility Nama (If not instituti	ocation of Dea	November 14, 1999 2:00 P.M. ocation of Death 4c. County of Death									
annner	Bon Secours Ho	spital			142	Baltimor			/A			
eral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yaar	If Undar 24 Hrs.	8. Data of B	irth	-	(Stata or Foraign		
tor	213-86-5011	MM 2□ F	31	Yrs.	Months Days	Hours Min.		27 68	M.D.			
	Usual Residence of Decedent		140.00	- 100						70 40 11 1		
3	10a. State 10b. Count	У	10c. Ca	ty, Town or Loc	cation					Inside City Limits		
octo	MD N				Q Tas 2 110							
Director	10e. Street and Number				10f. Zip Code			10g. Citizan of V	Vhat Country?			
rai	3413 Croydo	n Road		6 1.0	212		* **	U.S				
Funeral	11. Marital Status	Armed F		,S. 13. V	Yas, specify Cub	lispanic Origin? (S an, Mexican, Puart	o Rican, atc.)	Blac	e - Amarican Ir ok, Whita, atc.	noian,		
if item 27 is marked other than "netural", or itema 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at or other treumatic event, the Medical Examiner must be notified at or other them.  To Be Completed by Funeral Director	1 XNever Married 2 Ma 3 Widowed 4 Divorce	If Yas G	2 No ive	1	□ Yas ZXXVo	Specify:		Specify	Black			
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	(Specify only high	est grade completed		(Giva I	kind of work dona OO NOT use retire	during most of world)	king					
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Be C	17. Father's Nama (First, Middle						na (First, Middl	a, Maidan Sumam				
atic event, To Be C	Albert J. Crump Sr. Arlene							cs				
	19a. Informant's Name/Relation			19b. Mailin	g Address (Street	and Number or Ru			Stata, Zip Cod	Ja)		
	Albert Crump	SrFat	her	3413	Croydo	n Road,	Balt	imore M	d 2120	7		
	20s. Method of Disposition	2		Place of Dispos cemetery, crem	sition (Nama of latory or other pla	ce)	Data	20c. Location -	City or Town,	Stata		
poce.	1 ☑ Buriel 2 ☐ Cremation	Specify)	/ Ki	ng Me	morial	Park 1	1/20/9	9 Rand	allsto	own, Md		
ance.	21 Signature of Funeral Service	Licerson /		22.	Nama and Addre	ss of Facility						
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	23a Entar the disease, of heart feilure. Lis	or complications that	caused the deat						Apr	proximata arval Between		
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edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that imitiated events resulting in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):											
Physician/M		d										
by Physician/Me	Part II. Other significant condit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?			
							1 Yes 2 No 3 Probably 4 Unknown					
Completed by							24a. Wa	s an autopsy formed?	availab	eutopsy findings ble prior to ation of causa		
E							15	Yas 2 No	10/10	s 2 No		
	25. Was case referred to medic	al				26. Place of Dec			1	10 20110		
0	axaminer? XIX Yas 2 ☐ No	Hoenital:	Inpatient 2	ER/Outpatien	3□ DOA OH	her:		sidence 6 Oth	ar (Specify)			
	27. Manner of Death	28a. Data	of Injury oth, Day Year)	28b. Tima of	P 28c. Inju			how injury occur				
to		tigation		Injury	_ M 1	nk≀  Yas 2∏No	UNKN	OWN				
Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be detarmined 4 ☐ Homicide  6 ☐ Could not be detarmined  7 ☐ Could not be detarmined  8 ☐ Could not be detarmined  8 ☐ Could not be detarmined  9 ☐ FOUND 1:15  1 ☐ FOUND 1:15  1 ☐ FOUND 1:15  1 ☐ FOUND 1:15  1 ☐ FOUND 1:15  1 ☐ FOUND 1:15  2 ☐ FOUND 1:15  2 ☐ FOUND 1:15  3 ☐ FOUND 1:15  4 ☐ FOUND 1:15  5 ☐ FOUND 1:15  5 ☐ FOUND 1:15  6 ☐ FOUND 1:15  5 ☐ FOUND 1:15  6 ☐ FOUN							UNKNOWN  281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 900 BLK. ARLINGTON A BALTIMORE, CITY MD.				
edical		ing Physician: To the I Examiner: On the band man										
Medical Cert	29b. Signature and title of certific	er ,	.1	10	29c. Licen	se number		29d. Data signa	d (Month, Day	Year)		
	MAIN	utane	- N	(1)		O.C.M.E.		Novembe:	r 15 1	000		
	The second secon	-		- 1		Valalia Era		THUVE THE	1 1.3 4	ンフプ		
	30. Name and address of person	n who completed cen	se of death (Item	n 23a) (Type I					2 20, 2			

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State of Maryland / Department of Health and Mental Hygiene 99

ne 99 36238

				C	ertificate of	Death	B	leg. No.		0 5 6	10
		1. Decedent's Name (First, Middle, La.		2. Dete of Dee	th	Veer	3. Time of	Death			
	Physician (Modical	Thomas Edward C	omstock				November November	er 16 19	Year 999	7:40	am
	/Medical Examiner	4a Facility Name (If not institution, give	4b. City, Town, or	Location of Death	4c. County	of Deeth					
		940 Placid Cour	Arnold		Anne i	Arund	e1				
	Funeral Director	5. Social Security Number 6. S 049-24-6660	ex 7. Age (in 65	yrs. last birthda Yrs.	y) If Under 1 Yea Months Days					ece (State of try) ningto	
Aaryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hydlens. Is marked other than "natural", or hams 28s or 28s-1 ahow	A 11	10a. State 10b. County	100	City, Town or	Location				10	d. Inside Cit	y Limits
	serfah ouried setor	MD Anne Arundel Arnold							1 ☐ Yes 2 ☐ No		
	r hame 23e or 28e-far inner must be notified Funeral Director	10e. Street and Number 940 Placid Cour	t		10f. Zip Code 2101	.2	1	0g. Citizen of V USA	Vhet Count	iry?	
	al, or hams Luminar in by Fune	11. Merital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?  \$\times 2 \subseteq \text{No} If Yes, Give Year or Dates: 19		I. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2√3/No		Specify Yes or No- to Rican, etc.)	Blec	e - America k, White, a Whit	etc.	
5-0 72 hg	alcel de de	15. Decedent's Ed (Specify only highest gra	lucation	cation 16a. Decedent's Usua (Give kind of wor			ndrina	16b. Kind of Bu	siness/Ind	ustry	
	yglene. Ne then "neturn It, the Wedles!! Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lile	. DO NOT use retir	ed)	and a				
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Maryland	Be aver	17. Father's Name (First, Middle, Last)					ma (First, Middle, I	wa <i>iden</i> Sumam	18)		
T Nous	To To	Elmer Edward Coms  19a. Informant's Neme/Relationship (		10h Me	iling Address (Stree	Phyllis		City of Town	Ctate 7in	Codel	
Ma	Tan trau	Anita L. Comstoc							State, Zip	Code)	
	Heel Sther	20a. Method of Disposition		b. Place of Dis	O Placid position (Name of			21U12 20c. Location -	City or Tox	wn, State	
Baitimore,	Department of Heelth and Mental Hyglens important: If Itam 27 is marked other than any injury or other traumatic avant, the Hones.  To Be Compi	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify			rematory or other pl	ace)	44.5	Baltimore, MD			
Bail Permit	any in	21. Signeture of Funeral Service Licen	Q Z	to		ress of Fecility y Funeral ely Avenu			214	0.1	
£ /A	ns the burial-transit as the burial-transit wedical Examiner	Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	b. Due t	to (or as a cons	equence of):	ung				12)	N
P.O	igned by the attending to be detached for use as by Physician/Me	Part II. Other significant conditions of	dontributing to death but not Malli Tus	resulting in the	underlying cause g	given in Pert f.	23b. Did to	obaceo use cor		the cause o	
	should should	Hy pertens	Tion				24a. Wes e	in autopsy med?	con	ra eutopsy fi silable prior to apletion of ca death?	0
i Rec	age 2	Hyner	Memin				1 V	es 2 DNo		]Yes 2□	No
	rector, page Be Co	25. Was case referred to medical	7			26. Place of De	eath (Check only or		1		
of Vita	is certificate had director, page	examiner?	Hospital:	2 ER/Outpet	ent 3 DOA	ther:	Home 5 Reside		er (Specify	,)	
Islon	After the funant funant funant funant	27. Manner of Death  1 DN atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be detarmined			M 1[	Yes 2 No	28d. Describe he			l Routa Numi	ber.
0 0	od in by	4 Homicide	building, efc. (Sp	ecify)			City or Town	n, Stata)			
To the Hospital	within 24 hours stret deet To the Funeral Director: completely filled in by the Medical Certifical		yeiclan: To the best of my liner: On the basis of exam and manner stated.								)
Toth	To the	29b. Signature and title of certifier	1		29c. Licer	nse number	2	9d. Data signed	d (Month, L	Day, Year)	
		I fred M F	nen		n	17965		11/16	199		
	2	30. Name and address of purson who o	completed cause of death (	(Item 23a) (Typ	e, Print)	Are An	u o a li c	11/		401	
	State	31. Dete filed (Month, Day, Year)	32. Registrar's S	ignature	rigery 1	111	Mr you	Just	121	701	
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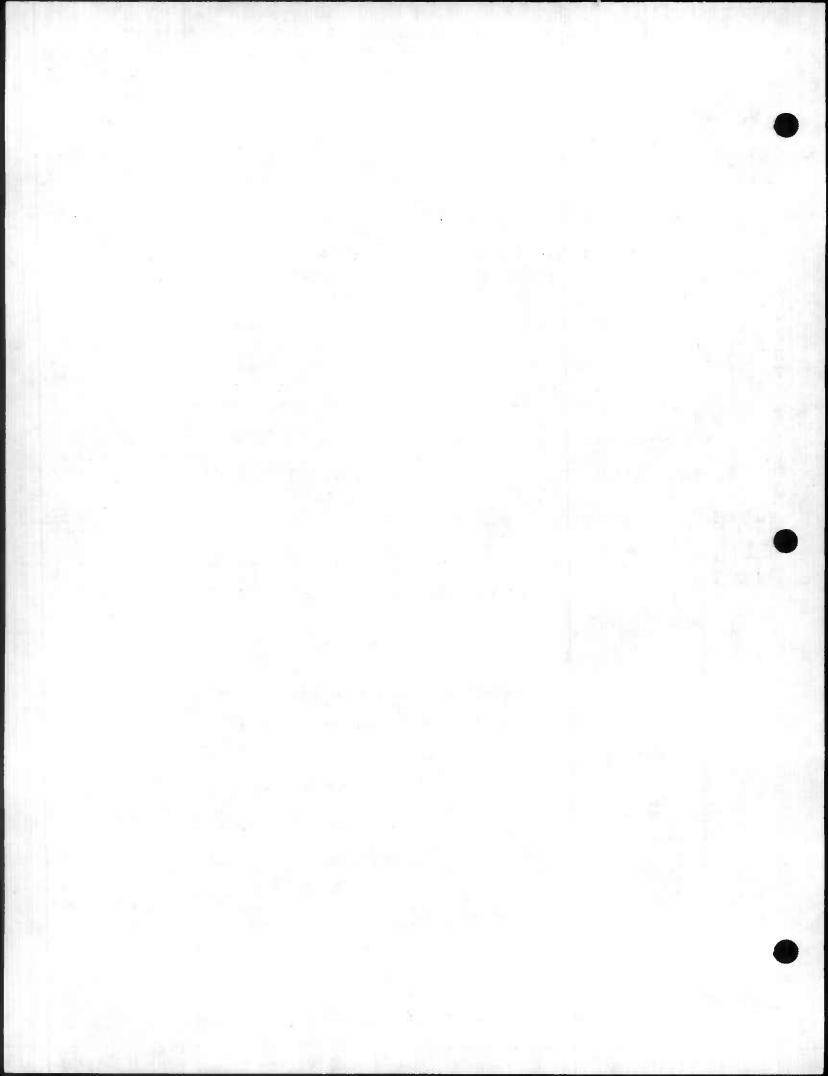
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State of Maryland / Department of Health and Mental Hygiene Q

36239 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** Edward 9:00 am A. Cichomski 15, 1999 Nov. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner 154 N. Potomac Street Baltimore
| Hunder 24 Hrs. | 8. Dete of Birth | Hours | Min. | (Month, Dey, Year) 5. Social Security Number If Under 1 Year 6. Sax 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 11 M 2□ F Months Days 215.01.1501 85 Yrs. Feb.10,1914 Director Poland Usual Rasidence of Decedent the Meryland 10a Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or hema 23a or 28a-f ahow other treumatic event, the Madical Examiner must be nothed at MD N/A Mas 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 N. Potomac Street 21224 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces?

X → Yas 2 □ No
If Yes, Give
Yaar or Datas: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Nevar Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Depertment of Health and Mentel Hygien important: if tem 27 ie merked other thu any injury or other treumatic event, the page. Merchant Seaman/Printer U.S. Coast Guard 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nema (First, Middla, Last) Be Ignanacy Cichomski Mary Zawol 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Genevieve Jones/Sister 154 N. Potomac St Baltimore, Md. 21224 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stata 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Stanislaus Cem. Baltimore, Md. 11/18 22. Name and Address of FacilityMoran-Ashton-Dabrowski 21. Signature of Puneral Service License Jah alexo 3000 E. Baltimore St. Baltimore, Md.21224 23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical HR Immediate Cause (Finel disease or condition resulting in death) ALDICA Examiner Due to (or es e consequence of): Examine RTERZIO Schritz physician and s the burial-transit certificate be asscuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): 80 for use es The law requires that the death P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the the 2 Probably 4 ☐ Unknown 1 Yes 2 No HYPOTTY rois signed b Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Be Completed 24e. Wes en eutopsy performed? peen hes 1 Yes 2 TO 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Seturel 2 Accident death. 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 - Homicide 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner steted. Medical 29b. Signeture end wile of contifier 29c. License number 29d. Date signed (Month, Day, Year) 24276 30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print) 10 )imor 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 1999 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36241

			Certificate of Death	Reg. I	No. 99	30240				
Physician	Decedent's Name (First, Middle, Last)  OFFICE  M		AMDDELL	2. Dete of Death	Day Year	3. Time of Death				
/Medical Examiner	GENE M.  4a Fecility Name (If not institution, give street end numi			r Location of Death	16, 1999 4c. County of Death					
	18249 FALLS ROAD  5. Social Security Number 6. Sex 7 7	. Age (In yrs. last birti	HAMPSTEAT		CARROLL	1 /0				
uneral rector	171-24-9388 1™ 2□F		Yrs. Months Days Hours Mi		PENN	place (State or Fore				
f show	Usuel Residence of Decedent  10e. Stete 10b. County  Maryland Carroll	10c. City, Town Hampst				10d. Inside City Lim				
r items 23a or 28a-f si otrer must be notified Funeral Director	10e. Street and Number 18249 Falls Road		10f. Zip Code 21074	de 10g. Citizen of WI U.S.A.						
by E	11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Was Deced Armer Force 15 Yes 2 If Yes, Give Yeer or Det	No WWITT	13. Wes Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Bleck, White, Specify: Whi	, etc.				
ther than "naturn ent, the Madical." Completed	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondery (0-12)  College (1-4)	(ac E.)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking	. Kind of Business/In					
Con	12	S	ales Representative		Engineeri	ng				
other traumatic event, the M	17. Father's Neme (First, Middle, Last)  Tom Campbell		Edna	eme <i>(First, Middle, Maid</i> Minto:						
T	19e. Informent's Neme/Reletionship (Type, Print)	19b.	Meiling Address (Street and Number or I	Pural Poute Number, Cit	y or Town, State, Zi	p Code)				
er trau	Rose Ann Campbell (wife)	18	249 Falls Rd. Har	mpstead N	MD 2107	4				
any injury or other tr	20e. Method of Disposition  1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from St 4 ☐ Donetion 5 ☐ Other (Specify)	cemeters	Disposition (Name of y, cremetory or other place) .nd Veterans Cemeter	1	Location - City or T Garrison					
eny inju	21. Signature of Funeral Service Licensee	2	22. Name end Address of Facility 1 1630 Edmondson Ave	Vitzke Funer						
	23a. Pert1. Enter the disease or complications that day	used the deeth. Do n			SVIII & PID	Approximete				
miner	Immediate Cause (Final disease or condition resulting in deeth)  a. A Zheimers Wisease (6)  Due to (or es a consequence of):									
Day the attending prystolan end etached for use as the burial-transit.  Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest  Due to (or es e consequence of):  Due to (or es e consequence of):									
ched for use	Pert II. Other significant conditions contributing to dea	th but not resulting in	the underlying cause given in Pert I.		Did tobacco use contribute to the cause of dea					
X 0 .				1 Yes	200 No 3 □ Pro	obably 4 Unkr				
should should				24a. Wes en eu performed	? 9	Vere eutopsy tinding vailable prior to ompletion of cause I death?				
Pege 2				1 ☐ Yes	21000 1	□Yes 2016				
Be	25. Wes case referred to medical examiner?			eeth (Check only one)						
T D	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Ing 27. Menner of Deeth 28a. Dete of			Home 5 Residence		ify)				
Location of the second of the	1 Naturel 5 Pending (Month, 2 Accident Investigation		injury Work?  M 1 Yes 2 No							
ed in by	determined 286. Place 0	f Injury - At home, fer l, etc. <i>(Specify)</i>	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,				
completely filled in b	29e. Certifier (Check only one)  1 Certifying Physician: To the base and menne	is of examinetion and	deeth occurred et the time, date end platfor investigation, in my opinion, death oc	ce, and due to the cause curred et the time, date e	(s) end menner es : and place, and due !	stated. to the cause(s)				
We	29b. Signature and title of certifier / buck	16/N	29c, License number 0 370	7. 41	Date signed (Month,					
	30. Name end address of person who completed cause David J Lorecus MD Ba	of deeth (Item 23a) (I	10NGreene St. Books	Baltoma	12120	1				
State Registrar	31. Dete filed (Month, Dey, Year) 32. Reg	istrar's Signeture	& Sporks							

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No. 181131 Bearing to March

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State of Maryland / Department of Health and Mental Hygiene 99

			Oldio of Mary		ertificate of			g. No.	36241		
	21	1. Decedent's Neme (First, Middle, Las	11)				2. Dete of Death Month		3. Time of Deeth		
	Physician /Medical	Madeline Marie	Mills Dr	esser			Novembe		999 1900		
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or Location of Death 4c. County of Deeth					
		Anne Arundel Med	lical Center			Annapolis	5	Anne A	rundel		
	Funeral Director	217-30-4243	9X 7. Age (In y	rs. last birthd Yrs	Months Davs	If Under 24 Hrs. Hours Min.	(Month, Day,		9. Birthplece (Stata or Foreign Country) Delaware		
	2 2	Usuet Residence of Decedent  10a. State 10b. County	100	City, Town or	r I continu				10d. Insida City Limits		
e Maryte	Maryla me-faho uted	MD Anne A		Annapo					1 ☐ Yes ঽৄCNo		
	or 28	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?		
	th will will will will will will will wil	1205 Tyler Avenu	e		21	403		USA			
21215-0020 d within 72 hours after dea piene.	within 72 hours after death with the Maryland ene. than "natural", or thems 23s or 23s-1 show he Medical Evaration must be notified at empleted by Furneral Director	11. Merital Status  1 □ Never Merried 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1 U,S. 1	Was Decedent of H     Yes, specify Cube     □ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	Bleck,	American Indien, White, etc. White		
5-0	ed within 72 hor ygiene. Her than "naturn It, the Wedical Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. De	ocedent's Usual Occup live kind of work done le. DO NOT use retired	pation	ina 1	6b. Kind of Busi	iness/Industry		
2	d within plene.	Elementary/Secondary (0-12)	College (1-4or 5+)	1	e. DO NOT use retired	d)	" · · · · ·				
	71 7 1 1	6	1155	Но	memaker			Own Home			
pu	and Mental Hygiens.  Mental Hygiens.  Merked other than matte avant, the Mental avant, the Mental avant, the Mental avant avan	17. Fether's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Sumeme)			
yia	should be nd Mental marked o armatic av	Alfred Heller				Mary Chr	istine J	ensen			
Maryland	2 sho and la m	19e. Informant's Neme/Relationship (7			ailing Address (Street						
		Nancy Owens (Dau	_		0 Old Bird						
0 -	00	20a. Method of Disposition  1 Parial 2 Cremetion 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Hillcrest Cemetery  11/22 Annapolis, MI									
Balti	pemit. Pag Department Important: if any Injury o	21. Signature of Funeral Service Licen			22. Nama and Addra Hardesty	ss of Facility Funeral	Home, P.	Α.	No.		
-		23a. Pert1. Enter the disease, or comp	plications that caused the d	eath Do not		ely Avenue			21401 Approximete		
4	Dhusisian	shock, or heart teilura. List only of	ona cause on each line.	oddi. Do not	one are more or eya	119, 0001 00 001 010	or roop rotory one		tnterval Between Onset end Death		
7	Physician /Medical Examiner	Immediete Cause (Finel disease or condition resulting in death)	a	upo	xi A				8lus		
			Due to	(or as e con	sequence of):	· AASTO!	· David	0	2000		
	min min		ь.	JULL	1 rexp	MATOR	1 raw	ane	20000		
68760,	ifficate be assocuted giphysician and as the bunal-transit										
_		resulting in death) Last	Due to (or as e consequence of):  Succur A, Utury						3 wouths		
Box	death certification of for use as						1				
o	0 00 -	Part II. Other significant conditions co		resulting in th	e underlying cause giv	ven in Pert I.	23b. Did tot	1	ribute to the cause of death?		
0	be do	Chun	sulus de	pur	dust 1)	118 SULTS	1 🗆 Ye	2 No 3	3 Probably 4 Unknown		
of Vitai Records,	N 25 G	Chin	uc Atru	rd F	ibrillos	u.	24a. Wes an perform	eutopsy ned?	24b. Wara autopsy findings eveilable prior to completion of cause of deeth?		
Œ	The law ate has b page 2 st						1 ☐ Ye	s 2 000	1 □ Yes \$2No		
ita	certificate irector, pag	25. Was case referred to medical				26. Place of Deet	h (Check only one	9)			
>	Physician: this certific ral director, To Be (	examiner?	Hospital: 1 Hopatient 2	☐ ER/Outpa	tient 3 DOA Oth	her: 4 Nursing Ho	me 5 Resider	nce 6 Other	(Specify)		
	After fune	27. Manner of Death  1/ Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Tim	e of 28c. Injur	ry et rk?   Yes 2   No	28d. Describe ho	w injury occurred	d		
Division	bal or Attanding P is after death.  In Director: After to de in by the funeration: Certification:	3 Suicide 6 Could not be 4 Homicide detarmined	28e. Place of Injury - A building, etc. (Spe	t homa, farm,	street, factory, office		28f. Location (Str. City or Town,	eet end Number , State)	or Rurel Route Number,		
	Hospit 24 hours Funer tely fill	29a. Cartifier (Check only one) 1 Certifying Phy one) 2 Medical Exam	reician: To the best of my iner: On the basis of exam and manner stated.	mowledge, de ination and/o	eath occurred at the tir r investigation, in my o	ma, data and place, opinion, death occurr	and dua to tha ca red at tha tima, da	use(s) and mannita and place, an	nar as stated. Id dua to tha causa(s)		
	within 2 To the compla	Est. Section (Single Internal									
		1/Jul Xo	un	S	00.	8317		11/16	8199		
	7	30. Neme and address of person who co	completed cause of death (I	16m 23a) (Tyr	pe, Print)	idgely k	ture. An	UWAPON	lis, moditul		
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	mature		1 1			1		
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State Registrar

DHMH 16 Rev 6/95

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31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Mildred Earchart 4:03 am 99 6 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Medical Center 301 St. Paul St. Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign
Country) 1 ☐ M 2 🕱 F Deys Feb. 20, 1929 Maryland 70 216-22-2611 Usuel Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore City Baltimore X⊠ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 315 E. Fort Ave. 21230 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education (Specify only highest grede completed) 16e, Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 10 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Ollie Hood Mary Lowman 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Darlene Earehart/Daughter 315 E. Fort Ave., Baltimore, MD 21230 20b. Pleca of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete Nov. IT. 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5 Other (Specify) Metro Crematory, Inc. 1999 4 Donation Catonsville, Maryland 21. Signature of Funeral Service Licansee 22. Name end Address of Fecility
Kirkley-Ruddick Funeral Home P.A. ava 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth metastatic Colon Cancer Immediate Ceuse (Final disease or condition resulting in death) 6 mos Due to (or es e consequenca of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest Due to (or as e consequence of) Due to (or es e consequence of): Pert if. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? ypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 20 No 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 28h Time of 28c. Injury et Work? 5 Pending

Physician /Medical **Examiner** 

Examiner

Physician/Medical

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**Physician** 

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**Funeral** 

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28a-f show

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7 le marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. International internatio

Maryland 21215-0020

Baltimore,

the Maryland

death

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Director: After this certifications Hospital 24 hours a

To the Hosp within 24 ho To the Fune completely fi

Registrar

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1🗷 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. (Check only one)

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end pieca, end due to the ceuse(s) end menner steted. 29b. Signeture end Vile of cartifier 29c. License number

29d. Date signed (Month, Day, Year)

MD completed cause of deeth (Item 23e) (Type, Print) DO053641

11-16-99

30. Neme end andress of person who

301 St. Paul St. Balto. MD 21202 MD Michelle 31. Dete filed (Month, Dey, Year) Signatu a

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q 36244 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 67h FIELDS LEON 1999 5.45 P.M NOU /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner SAMARITAN HOSPIT 0000 BACTIMORE 8. Date of Birth /(Month, Dey, If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. Months Deys Hours 10 M 2 F Director South **Usual Residence of Decedent** the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Directo nois 10s Stre et and Number 10f. Zip Code 10g. Citizen of What Country? Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U.S. Armed Forces? 11. Merital Status Bleck, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ₩idowed 4 Divorced Year or Dates: "natural" Mer Ican Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiena. Important: If Item 27 Ia merked other than "I any Injury or other traumetic event, the West Elementary/Secondary (0-12) College (1-4or 5+) Tion Val 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) (50n 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) d 20b. Plece of Disposition (Neme of cametery, cremetory or other) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) (0 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Jose Aug NOT se, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical fmmediate Cause (Final ASPINATION 9 N tumania disease or condition resulting in death) Examiner Due to (or as e consequence of): LARCAE ISCHEMIC CEREBROOASCULAR LEFT CIDED physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACCIDENT Due to (or es a consequence of): Box 68760, an/Medical Due to (or as e consequence of): P.0. been signed by the a should be detached Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ℃Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate rospital or Attending Physicien: The 24 hours after death. 25. Was case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural 1 Tyes 2 No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. odical 29a. Certifier tely (Check only one) 8 8 within To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Nov. 16th 1999 MiD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 360 I LOCAL RAVEN BUD

Registrar **DHMH 16 Rev 6/95** 

State

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31. Date filed (Month, Day, NOV

RAMPERSAD

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- MARA

32. Registrer's Signature

TO GOOD SAMARITAN HOSPITAL BALT MO 21239

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death WALTER November 14 4b. City, Town, or Location of Death
BALTIMURE 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Deeth BALTIMORE GAMARIAN HOSP OF MARYLAND If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)

June 19, 15 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 10XM 2□ F 83 1916 Baltimore Co., MD. 220-07-7050 Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 4209 Mispillion Road 21236 U.S.A. 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 2 (No If Yas, Give Year or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) 11. Marital Status 14. Race - Amaricen Indian. Bleck, Whita, atc. 1 Nevar Marriad 2 Married 1□ Yas ŽŽNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5 yrs. Superintendent n/a Gen Star 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Harry A. Fitch Debora McLean 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Hazel M. Fitch (Wife) 4209 Mispillion Road Baltimore, MD. 21236 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 11/18/99 Jarrettsville, MD. 21084 Jarrettsville Cemetery 21. Signatura of Funaral Sarvice License 22. Nama and Addrass of Facility E.F.Lassahn Funeral Home 11750 Belair Road Kingsville,MD.21087 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immadiata Causa (Final disaasa or condition resulting in daath) INTRACEREBRAL BLEED Due to (or as a consaquance of):

HYPERTENS ON

Dua to (or as a consequence of): NEUMONIA Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24a. Was an autopsy 24b. Wara autopsy findings available prior to complation of ceusa of deeth? LARDNIC REMAN ISBUFFICIENCY (DROWARY DISTASE 1 Yas 1 Yas 2 LNO 26. Place of Deeth (Check only ona)

**Physician** /Medical **Examiner** 

physician and the buriel-transit

certificate

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After

within 24 hours efter daeth To the Funeral Director: / complately filled in by tha

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Hospital

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Certification: To

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The law requires that the death certificate be asscuted

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician:

Depertment of Health ar Important: If item 27 is any injury or other trau

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Peges 1 end 2 should be filed within 72 hours after or sent of Haalth and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Iter

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

traumetic event, the Medical Examiner must be notified at

the Marylend

death v

Examiner Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avents resulting in daath) Lest Physician/Medical þ Completed

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

25. Was casa refarred to medical axaminar?

1 Yas 2 No 27. Manner of Death

6 Could not be

28a. Deta of Injury (Month, Day Year) 5 Panding invastigation

Hospital: 1 Inpatiant 2 EP/Outpatient 3 DOA 28b. Tima of

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

29a. Cartifiar (Check only one)

Natural

2 Accidant

3 Suicida

4 Homicida

Cartifying Physician: To tha bast of my knowladge, daath occurred at tha tima, data end place, and dua to tha ceusa(s) and mannar as steted.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the ceusa(s) end mennar stated.

29b. Signature and title of certifier

29c. Licensa numbar

29d. Data signed (Month, Day, Yaar) Horember, 14th, 1995.

28f. Location (Streat and Number or Rural Route Numbar, City or Town, Stata)

30. Nama and addrass of person who complated cause of death (Itam 23e) (Type, Print)

SAMARMAN HOSP RE MARYLAND INC, 5207 LOCH RAVEN BLUD, MID 21239 31. Data filed (MoNOW, 1009 1999 32. Registrar's Signatura

State Registrar

- Land Market

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q amend item 10e per fh g777 11/23/99 ah Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** Ruth Wilcox Finlayson Nox 2:35 am 99 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Undar 24 Hrs. 8. Date harlestown Baltimore Care enter 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Days Hours 10 M 20 F 82 215-10-8583 Maryland Director Usual Residenca of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f shov idical Examiner must be notified at 1 Yes 2 No Director Baltimore Catonsville 10e. Street and Number 719 MAIDEN CHOICE LANE 10f. Zip Code 10g. Citizen of What Country? 5906 Edmondson Avenue BR332 21228 U.S.A. Funeral deeth 12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Dates: Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: If item 27 ie marked other than "natural", or iter any injury or other treumatic event, the Medical Examina-1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Secretary American Trading Product 18. Mother's Name (First, Middle, Maiden Sumame) 17, Fathar's Name (First, Middla, Last) Be Emma A. Audoun Stuart R. Wilcox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice Hands (Daughter) 1916 Clifden Road, Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 4 □ Dorlation \$ □ Othar (Specify) Druid Ridge Cemetery 11/20/99 Pikesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata tnterval Between Onset end Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Cerebro Vascular Accident Examiner Due to (or as a consequence of): Physician/Medicai Examiner physician end the burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): 980 P.O. | 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ò 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Be Completed 20 No 1 Yes 2 No 1 Tyes certificate 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 1 DNetural 28c. Injury at Work? 28d. Describe how injury occurred Aftar Hospital or Attending 5 Pending investigation To the Mospital or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) November 18, 1999 5/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Salaz

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And Kes 31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

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32. Registrar's Signature

Lane, Catonsville, MD, 21228

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q 36247 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Rose Giammona 15, 1999 10:40am November /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Stella Maris 2300 Dulaney Valley Rd. Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day Year) 12-8-1905 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplece (Stete or Foreign **Funeral** Days Hours 1 M 2 X F Months Pafermo, Sicily 220-48-5223 93 Director **Usual Residence of Decedent** the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Itam 27 is marked other than "natural", or itams 23a or 28a-1 show ury or other traumatic avant, the Medical Examinar mast be notified at 1 Yes 2 No Director n/a Baltimore 10a. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21206 5424 Hilltop Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married White 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesaler/Retailer Produce 8th Baltlmore, Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Vincent Garofalo Cira Teresi 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2203 Fox Hunt Lane, Timonium, Maryland 21093 Shirley Iacoboni 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete permit. Pages Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 11/18/99 Baltimore, Maryland Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerat Service Licenses 22. Name end Address of Fecility Joseph N. Zannino Jr. Funeral Hm naria y Zannero 263 S. Conkling St., Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner attending physician and for use as the burisi-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or es a consequence of) signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records. Š 24b. Were eutopsy lindings available prior to completion of cause of death? should should 24a. Wes en eutopsy Completed page 2 has 1 ☐ Yes 2 ☐ No 2 12 No 1 Yes Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Neturat 2 Accident 5 Pending investigation 4 hours after death.

\*uneral Director: After ely filled in by the fur 1 | Yes 2 | No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) in 24 hour. the Funeral Direction of filled in by 28e. Place of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) à 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 1053283 30. Name and address of per plotest cause of death (Item 23a) (Type, Print) Soull St, Bellina MD 21230 Henor15 32. Registrar's Signatu 31. Dete filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

Registrar

NOV 1 9 1999

MON TELL NOW

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Gilbert Novembe-Dey 17, 1999 **Physician** W. George 12:00 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Baltimore Franklin Woods Nursing Center 8. Date of Birth (Month, Dey, Year) Aug. 25, 1914 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
N. Carolina 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Deys Hours 85 Yrs. 240-09-3206 Director Usuel Residence of Decedent with the Marylenc 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar mast be notified at 1 X Yes 2 □ No Baltimore N/A Director Maruland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21205 4907 E. Chase Street Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indien. 11 Marital Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after on the of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or ite 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 YNo Specify: White Specify. PV 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Manufacturing Welder 6th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Strickland Nonie Henry Gilbert 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 5 Lisa Ct., Baltimore, MD 21237 Mrs. Judy M. Zuk (daughter) other t 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20e. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Injury or permit. Page Department of Important: if sny injury or once. Bel Air Mem'l Gardens 11/20/99 Bel Air. Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** COPD /Medical Immediete Ceuse (Fine 10 405 disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner certificate be executed physicien end the burial-tren Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medicai Due to (or es e consequence of): 80 use Po Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown CENE BONO WASTULON ARE OFUS Completed by 24b. Were eutopsy findings eveilable prior to CANCER 24a. Was en eutopsy completion of cause of deeth? Attrino fle = nos. 5 1 Yes 2 No 1 □ Yes 2 □ No Division of Vital or Attending Physician: funeral director 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Neturet 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Hospital

State Registrar 31. Dete filed (Month, Day, Year) NOV 1 9 1999

29b. Signaturerand little of sermie

29a. Certifier

(Check only one)

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Hospirmor, BACO, Nol 21237

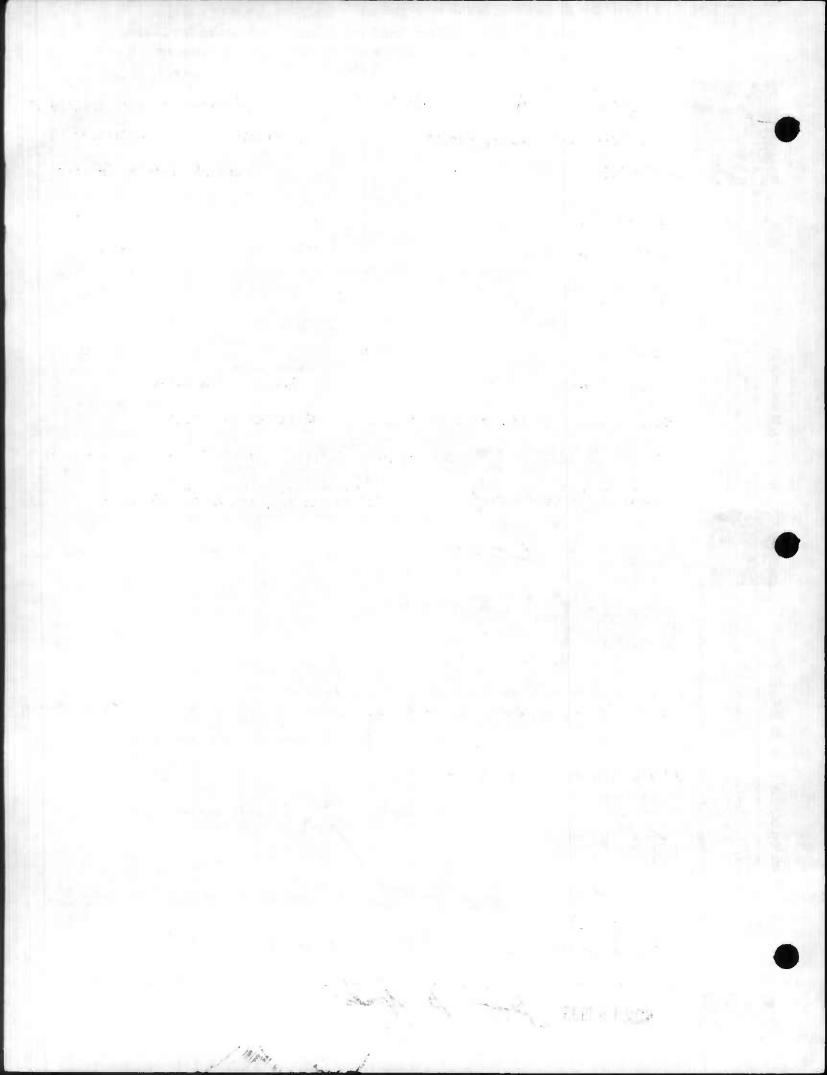
🗠 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner steted.

29c. License number

29d. Date signed (Month, Dey, Year)

30, Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 35 PM Month GOODMAN LIMMIE 11-14-4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth BALTIMORE If Undar 24 Hrs. GLEN NURSING HOME 6. Sex 1 ☑ M 2 ☐ F H Under 1 Vea Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Deys Months Hours 263-10-3634 01-08-18 Usuel Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA mo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 523 LYNHURST STREET 21229 NSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Black, White, atc. 12, Wes Decedant Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 Yas 2 No Specify: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CHY OF BALTIMORE NIA USTODIAN 6TH GRADE 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nema (First, Middla, Last) GOODMAN DARNELLER LIMMIE LEWIS 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) St. SON BAUTO. MD. 21229 LYNHURST DERRICK GOODMAN 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from Steta BALTO. MD 4 ☐ Donetion 5 ☐ Other (Specify) 11-19-99 CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MO. 21229

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Appropriate the disease of the cause on each line. Approximata Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) RENAL DISEASE STAGE YEAR CARDIOVAS CULAR DISEASE UNKNOWA YPERTENSIVE Due to (or es e consequence of): Due to (or es a consequence of): 23b. Dfd tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 ™ Unknown STROKES - MULTIPLE 24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy performed? completion of causa BILATERAL PNEUMONIA 1 ☐ Yes 2 🗷 No 1 ☐ Yas 2 ☐ No 26. Pieca of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28b. Time of 1 Neturel

**Physician** /Medical Examiner

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Completed

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Box 68760

Division of Vital Records, P.O.

or Attending Physician:

after death.

24 hours after Funeral Dire letely filled in b the Hospital

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completely

**Physician** 

/Medical

Examiner

Funeral

Director

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Items 23a

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or Nem any Injury or other traumatic event, the market has any injury or other traumatic event, the market has any injury or other traumatic event, the market has any injury or other traumatic event, the market has a page.

Director

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Completed

Examiner Sequentielly list conditions, if any, leeding to immediata cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Physician/Medical

Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.

ADVANCED DEMENTIA

25. Was case referred to medical examiner?

1 Yes 2 No

5 Pending Investigation

6 Could not be

28a. Dele of Injury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 ☐ Accident

3 Suicide

4 Homicide

155 Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier Kemal & Davemo

29c. License number D18362 29d. Date signed (Month, Dey, Year) 11-15-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMAL K. DANG M.D., 3455, Wilkens Ave, Suit 308. Balto. Md 21229 KOMAL K. DANG M.D. 31. Date filed (Month, Dey, Year)

NOV 1 9 1999

32. Registrar's Signature

State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedant's Name (First, Middle, Last) November 18 718 **Physician** Gardner Zenobia /Medical 4b. City, Town, or Location of Death Baltmore City 4a Facility Neme (If not institution, giva street end number) 4c. County of Death Examiner aryland reneral usportal If Under 24 Hrs. Security Number Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 230-12-5266 75 Director M.D. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD notifie NA Baltimore 8 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or items 23s or the Medical Examiner must be 4017 Liberty Heights Ave

1. Marital Status

1□ Never Married 2□ Married

3XXMidowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1□ Yes 2XXVo Hyer or Dates: Funeral 21207 U.S.A. 14. Raca - Amarican Indian, enobia Gardner Was Decedeni of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Bleck, White, etc. 1 ☐ Yes XXNo Specify: Specify: þ Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 12th grade 17. Fether's Name (First, Middle, Last) N/A na Be ould be Mental 7 is marked of traumatic evi Frank Carter Sadie Lancaster 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 of Health Hem 27 Maria Beane-Sister 4212 Ridgewood Ave, Baltimore Md 21215 20b. Piaca of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State XXSerial 2 □Cremation 3 □Removal from State Arbutus Mem. Park 11/22/99 Arbutus, Md 1. Signi ing of Funeral Service Ligen 22. Name end Address of Fecility March F/H West Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one dauge on each line 21215 Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease of condition resulting in death) /Medical neum onion arrure Examine Spiratory + brant. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Pulmonary Disease physician at the burial-t Box 68760 8 Physician/Medical 2 800 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Wes an autopsy Completed parformad? i certificate has i 1 Yas 2000 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28e. Date of Injury (Month, Day Year) 28c. injury et Work? 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of Certification: Aftar Attending 1 Matural 2 Accident 5 Pending 1 Yes 2 No investigation Director 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after b Hospital hours Funeral Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, end due to the cause(s) end manner stated. 34 To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name end address of person who completed cause of death (item 23e) (Type, Print) land Greneral Hospital Haider Sarrat 201.0 31. Dete filed (Month, Dey, Year) 32. Registrar's Signatura State Registrar

Maria Beane-Sister

4212 Ridgewood Ave, Baltimore Md 21215

Arbutus Mem. Park 11/22/99 Arbutus, Md

March F/H West
Mayor 4300 Wabash Ave, Baltimore Md 21215

## Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Do

ATHERINE A	1. Decedent's N		le, Last)			tificate of		2. Date of D			6251.
Physician	Catherine Ann George						NOV. 16, 1999				
/Medical Examiner	de Caellin Name		n, give street and no			4b. City, Town, or La			y of Death	2149 PM	
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Funeral	5. Social Security	y Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Bi (Month, D	rth	9. Birthpl	laca (Stete or Foreign
Director	220-13 Usual Residence		1□M 2∏F	20	Yrs.	Months Days	Hours Min.	July 2	27,1979	Texa	
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Man I	MD Anne Arundel Annapolis										1 Yes 2 □ No
ther death with the Mai from 23e or 28e-fe there must be notified Funeral Director	10e. Street and I	Number				10f. Zip Code			10g. Citizen of	What Count	try?
N Will	952 Aq	ua Cour	t			21401-	4743		USA		
9 6 6	11. Marital Statu	11. Marital Status 12. Wes Decedent Armed Forces				Was Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N	0- 14. Ra	ce - America	
09		1 Never Married 2 Married  1 Yes, Give  Yeer or Detes:				I ☐ Yes 2 ☐ No			Black, White, etc.  Specify: Amerasian		
72 hours natural; deal by		15. Deceder	nt's Education		16a. Deced	lent's Usual Occup	pation		16b. Kind of B	Business/Ind	lustry
Die n	Elementary/S	pecify only higher econdary (0-12)	st grade completed,	(1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)						
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be filed within 72 house is Hygiene. I other than *natura year, the Middle Be Completed	17. Father's Nan	ne (First, Middle	Last)	/ 1			18. Mother's Name	e (First, Middle	, Maiden Suma	me)	
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2 should end Men le marke eumatic		Neme/Reletion	ship (Type, Print)		19b. Mailir	g Address (Street	and Number or Run	al Route Numb	ber, City or Town	, State, Zip	Code)
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permit. Depentral Importa	21. Signature of	Funeral Service	Licensee	2		. Name and Addre					
Depermination of the second of	Hardesty Funeral Home, P.A.  12 Ridgely Avenue, Annapolis, MD 21401										
	23a. Pert1. Ente	or the disease, o	r complications thet	caused the dea			-			2230	Approximate
Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									1	Interval Between Onset and Death
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icete be executed physicien end s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of):										
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The level page 2								1 [2	Yes 2□No	10	Yes 2 No
certificate he rector, page	25. Wes case re	ferred to medica	1				26. Place of Deat				
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Hoepi 24 hour Funer tely fill			Examiner: On the b	asis of examine			me, date and place, opinion, death occur				
within 2 To the comple		nd title of contin		nner stated.		29c. Licens	se number		29d. Date sign	ed (Month	Dev Year)
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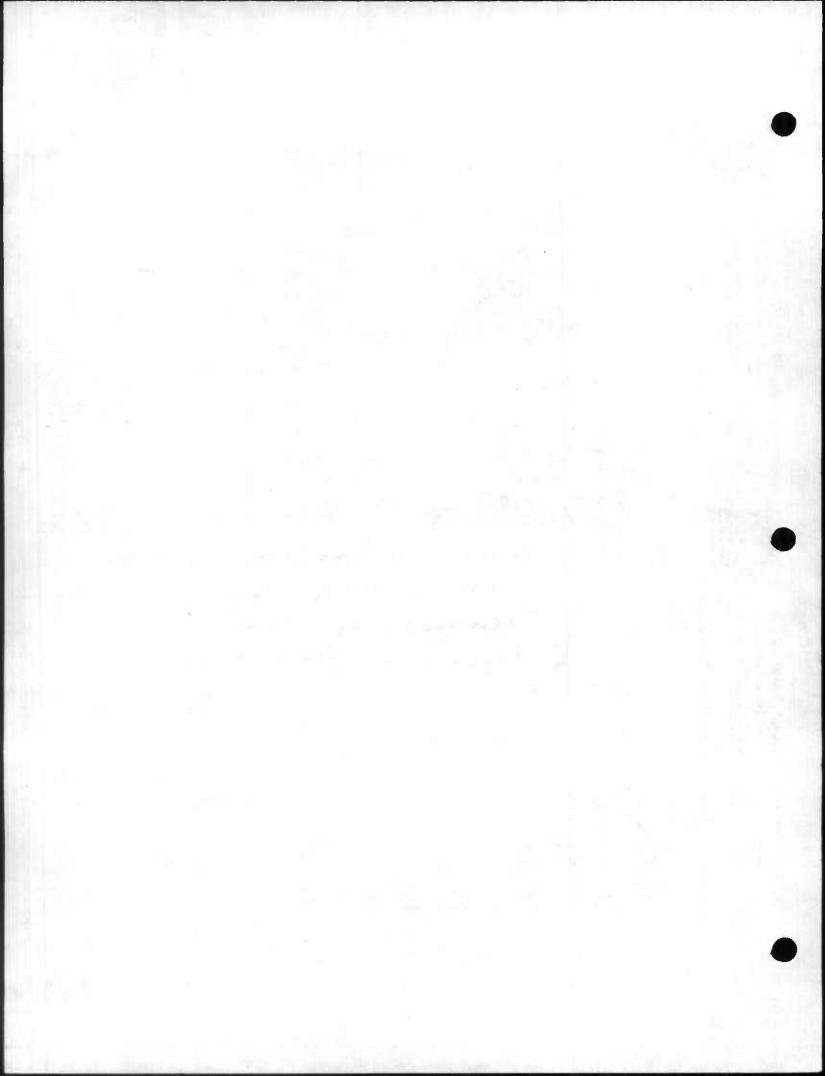
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	Physician /Medical									Nov.14	1,1999	rear	6:30 pm
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		Future Care								imore	N	/A	
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ior	Attending Indeath.  Actor: After by the funerification:	1 Neturet 5 Pending 2 Accident investige	ation	Doy ! oar,	n yory	М		Yes 2	No				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Daath 3. Time of Deeth Month Yeer Audrey Theresa Holthause 4:35 AM Nov. 19 1999 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Daath 6111 Rollingview Drive Eldersburg Carroll If Undar 1 Yaar | If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 5. Sociei Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Hours 1 ☐ M 2 🔀 F Vre 213-28-0444 66 Dec. 7, 1932 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll 1 ☐ Yes 🌠 ☐ No Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6111 Rollingview Drive 21784 USA 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Reca - American Indien, Black, White, atc. 1 ☐ Yes 2 ☐ (No If Yas, Giva Yaar or Dates: 1 Navar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest greda comp 16b. Kind of Business/Industry reda complated) Elementary/Secondery (0-12) College (1-4or 5+) 12 Corporate Secretary Insurance 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) John W. Sturm, Jr. Sophie Watroba 19e. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John R. Holthause, III 6111 Rollingview Dr., Eldersburg, MD 21784 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 11/22/99 4 Donation 5 Delhar (Specify Sparks, MD Jessops United Meth.Ch.Cem. 22. Nema and Addrass of Facility Lemmon Funeral Home 23a. Pert1. Enter the diseesa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximata interval Between Onsat and Death iver Metastases Immediate Causa (Final mo disease or condition resulting in death) an creatic Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Dua to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 24b. Wera eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 20 No 5 Rasidence 6 Other (Specify) 1 Tas 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Netural 2 Accident 5 Pending

Division of Vital Records, P.O. Box 68760,

The lew requires that the deeth certificate be executed

physician end s the burief-transit attending p signed by the al been signature is certificate has director, page 2 Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifice stelly filled in by the funeral director, I To the Hospital or within 24 hours efter To the Funeral Direcompletely filled in b

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

7 is marked other than "natural", or itsems 23s or 28s-f shor traumstic event, the Medical Examiner must be roulled at

permit. Peges 1 and 2 should be filed within 72 hours efter death w Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural" and vinjury or other traumatic events and vinjury or other traumatic events.

**Physician** /Medical

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Physician/Medical

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Certification:

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Medi

3 Suicide

29a Certifier

4 Homicide

with the Meryland

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

30. Neme end eddress of person who m

investigation 6 Could not be determined

/at

of deeth (Item 23a) (Type, Print) St Agnes Concer Certer
MD 900 Catan for Bolt Me

2. Registrar's Signatura

28a. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Straet end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36254

										Death			Reg. No.		
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Physician /Medical	_ (	Clyde Hi	icks									NOVE		1999	3:12 P
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 1999 Sharon Cameron Provan Harris November 11 9:48 am 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Hours 1□M 2QF Months Yrs. 57 224-54-4723 Dec. 9, 1941 Washington, DC Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Highland Drive 21037 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifte. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Apprentice Electrical 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fether's Neme (First, Middle, Last) James Byron Provan Nina Vivian Taylor 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina V. Taylor Elmer (Mother) 532 Highland Drive, Edgewater, MD 21037 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from State Mayo U.M. Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 11/15 Edgewater, MD 21. Signature of Funerel Sarvice License 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one causa on each lina. Immediete Ceuse (Finel disease or condition resulting in death)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

28a-1

"natural", or items 23a or

must be

Director

Funeral

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Completed

Be

the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important; if New 27 is marked other any injury or other to-

altimore, Maryland 21215-0020

Examiner Sequentially list conditions if eny, leeding to immediate causa. Entar Underlying

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Cause (Dissess or Injury thet initiated events resulting in deeth) Lest  Pert II. Other algnificant conditions co	C Due to (d	or as a consequence o	n:		
			g causa given in Part t.	23b. Did tobacco use co	ntribute to the cause of death?
Rence	Failsre			24a. Wes an autopsy performed?  1 ☐ Yes 2 ☐ No	24b. Were eutopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Wes case referred to medical		Lo DET L	26. Place of De	eth (Check only one)	
examiner?	Hospitel: 1 ☐ Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. tnjury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
27. Manner of Deeth    Nature  5   Pending Investigation	28a. Ptace of Injury - At h building, etc. (Speci	nome, farm, street, fact	ory, office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
29a. Certifier 12 Certifying Phy	sician: To the best of my knowner: On the basis of examine end manner steted.	owledge, death occurre etion end/or Investigati	ed at the time, date end plac on, in my opinion, death occ	e, and due to the cause(s) and me urred et the time, date end place,	anner as stated. and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be assocuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hunal-transit Division of Vital Records. P.O. Box 68760.

State Registrar

Medica filed (Month, Dey, Year) V 1 9 1999

29b. Signeture end title of certifier

29c. License number 0317

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (ttern 23a) (Type, Print)

NON T 3 1888 From & Species

D. L. H. M. M. D.

### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

36256

					Cei	tificate d	of Death		Reg. No.		0200				
		1. Decedent's Name (First, Middle			2. Date of De Month		Year	3. Time of Death							
de:	Physician /Medical	Pierce Jacks	son Hand	cock,	Jr			NOVEME		1999	1348 PM				
	Examiner	4a Facility Name (If not institution	_					r Location of Death	4c. Count	y of Death					
		MARYLAND GENE					BALTIMO								
н	Funeral Director	5. Social Security Number 252 86 5840	6. Sex 120 M 2□ F	7. Age (In you 49	s. last birthday) Yrs.	Months Da	ear If Under 24 Hours Mi		1950	9. Birthpl	lace (State or Foreign anta GA				
	g .	Usual Residence of Decedent  10a. State 10b. County		100 (	city, Town or Lo	antina					Od. Inside City Limits				
	aho ed an	GA		100.0							1 Yes 2 No				
	vith the Mar t or 28s-f all be northled	Ha:	.1		Gain	esvil		1	10g. Citizen of	What Count	1				
	T O O	4701 Shirley I	Rd.				0506		USA		.,,				
	r tems 23s	11. Marital Status		sedent Ever in	U,S. 13. V		of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No	- 14. Rac	ce - America					
21215-0020	by by	1 Never Married 2 Marri 3 Widowed 4 Ovivorced	Armed F ed 1 Tyes If Yes, G Year or I	2 No			Ouban, Mexican, Pue No Specify:	erto Rican, etc.)		ck, White, e					
2-0	"natural",	15. Decedent		1	16a. Deced	lent's Usual Oc	ccupation one during most of w	and in a	16b. Kind of B	usiness/Ind	lustry				
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and	See Se	17. Father's Name (First, Middle, Pierce J. Ha		SD				Name (First, Middle, Maiden Sumame)							
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a)	of Health item 27 other to	20a. Mathod of Disposition			Place of Dispo	sition (Name o	1	Date	20c. Location						
Baltimore, permit. Pages 1 al Deperment of Hea Important: if Item: any injury or othe	1 X Burial 2 Cremation		State A1	ta Vis			11/18/9			lle, GA					
	4 Donetion 5 Other (Sp 21. Signature of Funeral Service I					ddress of Facility									
Ba	Dep ve and	Marn	2.0.01	00	St	erling	g-Ashton				ome Inc.				
		23a Part 1 Enter the disease or	complications that	caused the de	73	6 Edm	ondson A	ve. Cat	onsvil	le,M	D 21228 Approximate				
4	Physician .	23a. Part 1. Enter the disease, or shock, or haert failure. List	only ona ceuse on	each line.	s s	or 0.10 111000 01	dynig, oddir do dardi	A	A		Intervel Between Onset end Death				
A	/Medical	Immediate Cause (Final	1	L	+01	1001	7 01	. 2	H	-	calonation				
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	deeth certificate be axecuted e ettending physician end of for use as the burial-transit siclar/Medical Examiner	Sequentially list conditions.	Ь.	Due to	(or as a conseq	uence of):	ajac	213	رسع						
oʻ	an el urial-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								1					
68760,	ficate be physicial street burners the burners edical	that initiated events resulting in death) Last	с	Due to	(or as a conseq	uence of):				1					
39	E 20 5	Tooling III doubly Edd													
Вох	at the deeth ce d by the ettendi letached for use Physician/I		d							1					
0	tha dee	Part II. Other significant conditio	ns contributing to d	leath but not re	sulting in the ur	derlying cause	given in Pert I.	23b. Did	tobacco use co	ontribute to	the cause of death?				
Δ.	ras that the de signed by the elbe detached by Physic							1 🗆	Yes 2 No	3 Prot	bably 4 Unknow				
Vital Records,	law requiras that las been signed b 2 should be deta npleted by PI							24a Was	an autopsy	24b. We	ere autopsy findings				
Ö	The law requir								ormed?	ave	ailable prior to mpletion of cause				
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on	tending P Jeath. tor: After t the funer	1 Natural 5 Pending		of Injury oth, Day Year)	Injury		Injury et Work? 1 Yes 2 No	1							
Division	2005	3 Suicide 6 Could r	ot be 28e. Plac	e of Injury - At ling, etc. (Spec	home, farm, str	eet, factory, off	ice			ber or Rura	l Route Number,				
=	tal or Attending P is after death. In Director: After led in by the funer Certification:	4 Homicide		City or To	wri, State)										
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b Medical Certi		xaminer: On the b				e time, date end pla ny opinion, death oc								
	within To the comple	29b. Signature and title of certifier	A A A A A A A A A A A A A A A A A A A			29c. Lic	ense number		29d. Date signe	ed (Month, I	Day, Year)				
	- 5 - 0	DO PT	Tarasa	a d	1)		OCME		NOVEMBE	R 15,	1999				

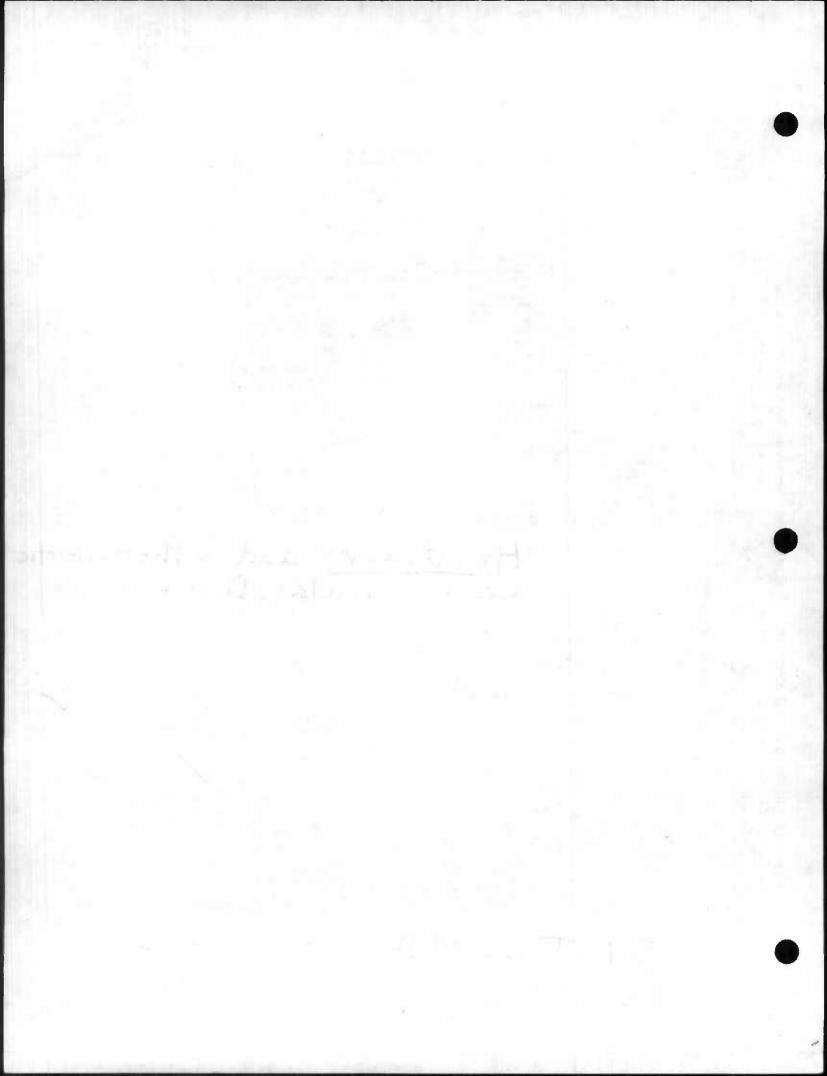
01 State

Registrar

JOSEPH Month, Day, Year) DHMH 16 Rev 6/95

tress of person who completed cause of death (Item 23a) (Type, Print)

Toseph (PESTMCIT11 Penn Street, Baltimore, Maryland 21201



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

99 36257

	•		Certif	icate of l	Death	R	eg. No.			
50.00	1. Decedent's Nama (First, Middle, Last)					2. Deta of Deal			3. Tima of Death	
Physician	Konget HI	INTER				Month	Dey 15	1999	14:34	
Medical	4a Fecility Nama (If not institution, give street	and number)			b. City, Town,	or Location of Deeth	4c. County	of Deeth	110	
Examiner	BON SICOUTS HOS	0	Bathono	o at I	Baltim	N 00 00				
The same of the same of	5. Social Security Number 6. Sex	7. Age (In yrs. last		Under 1 Year	If Under 24 h	Is. 8 Date of Birth		9 Birthplace	e (State or Foreign	
Funeral Director	250186933			onths Days	Hours M	Irs. 8. Dete of Birth (Month, Day,	Year)	Country)	Carolina	
	Usual Residence of Decedent	100				05-10-1	919	Douth	Outorina	
A H	10a. State 10b. County	10c. City, T	own or Location	on				10d.	Inside City Limits	
A	Many land	R.	altimor						1)∑Yas 2□No	
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F 0 F 0	100/ Mal/on Arrance			21217	7		-	d State		
ath 23	1004 McKean Avenue									
1215-0020 within 72 hours efter death with the Meryland and and "hear" natural, or ferm 23s or 28s-1 show the Medical Examinar must be notified at ampleted by Funeral Director	11. Marital Status 12. W	les Decedent Ever in U,S. med Forces?	13. Wes	Decedent of H s, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		e - American I ck, White, etc.		
D20 una esta Er, or t	1 Never Married 2 Married 1	ZiYes 2 □ No Yes, Give	10	Yes XXNo	Specify:		Specify	· Blac	·k	
DOO DOOUT	3 N Widowed 4 □ Divorced Ÿ	ear or Detes:						DIAC	.K	
1 21215-0020 ed within 72 hours eft ygleine. ser then "neturel", or it, the Medical Exert Completed by F	15. Decedent's Education (Specify only highest grade com	n 1	6a. Decedent (Give kind	's Usual Occup I ot work done o VOT use retired	ation during most of v	working	16b. Kind of Bu	usinass/Indus	try	
21215-0020 within 72 hours of within 72 hours of plane. The "metural", or then the control of th	Elementary/Secondary (0-12)	ollege (1-4or 5+)			0					
CA DEF	11th Grade	-0-	Pa	inter				Employ		
and Siled filed other avent.	17. Father's Nama (First, Middle, Last)				18. Mother's N	Name (First, Middle, I	Aaiden Sumem	16) OWA	1	
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de de de de de de de de de de de de de d	Part II. Other significant conditions contribut	ing to death but not resultin	g in the under	tying causa giv	en in Pert I.	23b. Did to	bacco uae co	ntribute to th	ne cause of death?	
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는 사람들 두			Outpatient 3	NOUTE	4 U NUISKA	g Homa 5 Raside				
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DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi		nd manner steled.		200 1:	n number	-	Od Dota -i	d (Month D	v Vacel	
6.₹6.8 5.46.8	29b. Signature and title of certifier	7	29c. License number 29d. Data signad (Month, Day, Year)							
10	TOVI leas	ue Mi	MD 17+322 11115 199							
1	30. Name and address of person who complete		la) (Type, Prin	) 4		2 0 4		-	_ ~	
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State	31. Date filed (Month, Day Year), 0 100	32. Registrat's Signature	14	1-						

But the same and the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15 2:25/14 4c. County of Dea 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day) 0 101 105 Ta 5. Social Security Number 218-28-8482
Usuel Residence of Decedent If Under 1 Year (In yrs. last birthday 9. Birthplace (State or Foreign 1□M 2XF Days Yrs. LOIY 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Noves 2 No 110 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify. 3 XWidowed 4 □ Divorcad 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zip Code) (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ramb 1500 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State emoria 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Facility Joseph List only one ceuse on each line. 0,00 Ka 21216 Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial 10hihuTES Orbhur f artery
Due lo (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Obstructive Pulmenoux Piscase 1 Yes 2□ No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yas 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1, Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending investigation 2 No 1 ☐ Yes 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the deuse(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

/Medical Examiner physician end the buriel-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this After 1 s efter death. To the Hospital o

**Physician** 

/Medical

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Physician/Medical Examiner

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Certification: To

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Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Menylend Department of Heelth and Mentlet Hybjene. Important: if them 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event.

Physician

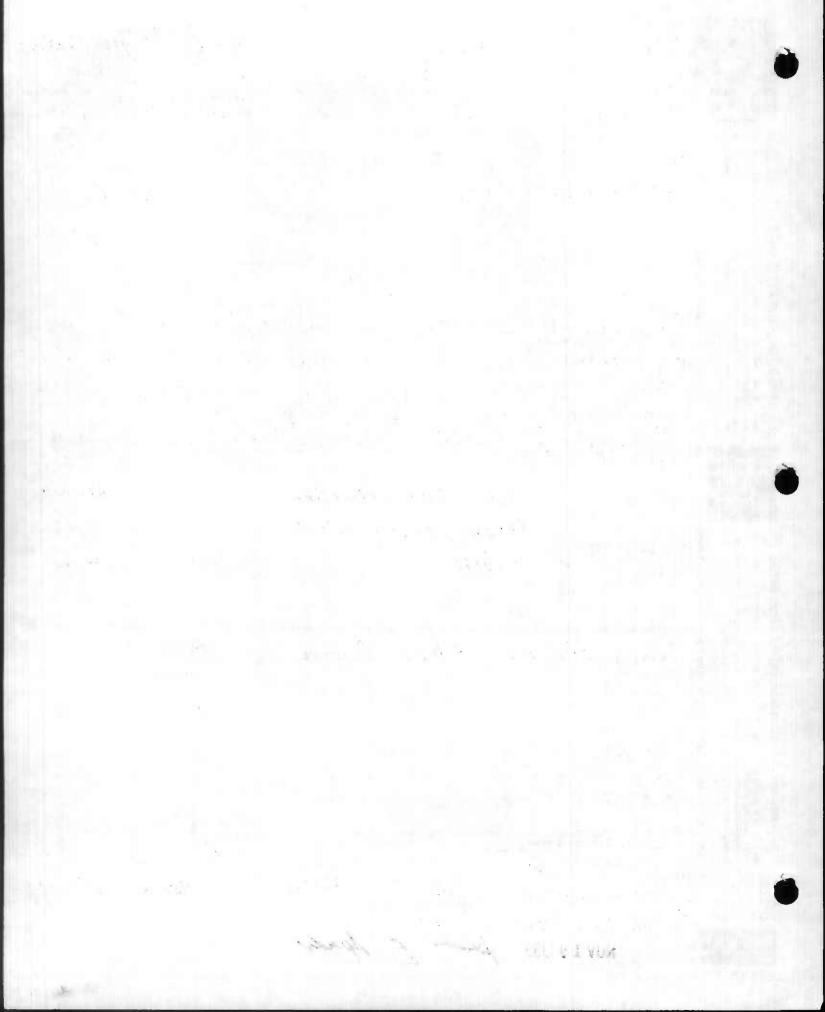
Baltimore, Maryland 21215-0020

Registrar

31. Date filed (Month, Day, Year) NOV 1 9 1999

STOKES W 32. Registrer's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 36259 Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death 2. Data of Death Month Day **Physician** Edward Nelson Kearney. Sr. Nover, Well 16, 1999 cation of Death 4c. County of Death 4120 P.M. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Rose da le 15/ If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July 2, 1918 BAITIMORE FRANKlin SQUARE Hospila, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10XM 20 F 213-20-7094 81 Director Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yas 2 X No Director Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8623 Silver Lake Drive 21128 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. Department of Health and Mental Hygiene.
Important: If them 27 is marked other then "natural", or frem any injury or other traumatic event, the manual page. Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 8th Grade Collega (1-4or 5+) Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Katherine Powers Maurice Kearney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8621 Silver Lake Dr., Perry Hall, MD Edward N. Kearney, Jr. (son) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from Stata 11/20/99 Baltimore, Maryland Gardens of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21. Signature of Funeral Service License Rober 1000 21236 23a. Part1. Enter the disease or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause or each line. Approximata tnterval Between Onset and Death Immediata Cause (Final diseasa or condition rasulting in death) neumonia week Due to (or as a consequence of): Examiner eners GRANULOMALOSIS Lweeks Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown þ 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 2 No 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mapner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 SNaturat 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Coutd not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

that the death certificate be asscuted Box 68760 Records, P.O. Division of Vitai

Baitimore.

**Physician** /Medical

Examiner

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The law requires Attending Physician: 6

n 24 hours after deeth.

Funeral Director: A bletely filled in by the fu Hospital To the Hosp within 24 hor To the Fune completely fi

**DHMH 16 Rev 6/95** 

State Registrar

Medical

31. Data filed (Month, Day, Year) NOV 1 9 1999

29a. Cartifier

(Check only one)

29b. Signature and title of certifie

29c. License numbe

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29d. Data signed (Month, Day, Year)

Klin Squake DR. BAITIMORE, MARYlAND

hARdon 32. Registrar's Signature

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

9000 FRANKlin

MON I 91993 Marie & Marie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1	Ameno	led	Item### PTII perPhyG	State 1777 11/19/	of Mar 99 EW	ryland /	Depa Ce	artment of rtificate o	Health f Deal	n and N		giene (	99. 3	36260	
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J.	Physic /Medi		Constance	R.			L	loyd			Nov.	3,	1999	12:27pm	
	Exami		4e. Fecility Neme (If not institution,	give street and n	um <i>ber)</i>				4b. City,	Town, or Lo	ocation of Deeth	4c. Co	unty of Deeth	127	
		_	William Hill						Eas		_		albot		
	Funeral		- Hartiselline Control	6. Sex 1 ☐ M 2 ☐ xF	7. Age (	(In yrs. last bi		Months Dey		der 24 Hrs. s Min.	8. Date of Birtl (Month, De)	, Year)	9. Birth	place (Stete or Foreign htry)	
	Director		Usual Residence of Decedent			97	Yrs.				May 30	, 1902	2 R.	[.	
	and *		10a. Stete 10b. County		1	IOc. City, Tow	vn or Lo	ocation						10d. Inside City Limits	
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	158 288 Inc.	Director	MD Talbot	L		East	on	10f. Zip Code				10a Citizen	of Whet Cou	ptp/?	
	3a or	百	501 Dutchman's	Lane				216				U.S.		,	
	be filed within 72 hours after death with the Maryland tial Hygiana. d other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Wes De		er In U,S.	13.	Was Decedent o		Origin? (Sp	ecify Yes or No-		Reca - Ameri	can Indien,	
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Baltimore, Marylar permit. Pagas 1 and 2 should by Department of Health and Mente Important: if Item 27 is merked any Injury or other traumatic evonce.			4 Donetion 5 Other (Sp												
Balt permit. Departr imports any inj		21. Signature of Funeral Service L Ronal		, Di	rector	- 22	2. Name end Add State Ar	iress of Fe 1atomy	<sup>cility</sup> 7 Boar	d, 655	W. Ba	1timor	e Street,		
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É	는 등 등	Certification:	4 ☐ Homicide determin	ned 28e. Pled build	a of injury ling, etc. (	Specify)	erm, str	reet, factory, offic	Θ		City or Tow	reer and iv n, State)	umber or Hun	el Route Number,	
	pltal ours eral filled	. 1	29a, Certifier 1 Certifying	Physician: To th	n bact of a	ny knowloday	dooth	n accurred at the	time date	and place	and due to the		-	totad	
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	To the Hospital or within 24 hours atta To the Funeral Dircomplataly filled in	M	29b. Signature end title of certifier	)	olatot	$\wedge$		29c. Lice	nse numbe	ər	2	29d. Date si	gned (Month,	Dey, Yeer)	
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 35251

				Certin	ficate of	Death		Reg. No.	2	0201				
5	1. Decedent's Neme (First, Middle,	Last)					2. Dete of De Month	eth Dev	Year	3. Time of Death				
Physician /Medical	Wallace C.	Long						per 14,		4:25 p.m				
Examiner	4a Facility Name (If not institution,	give street and numbe	7)			b. City, Town,	or Location of Deat		y of Deeth					
91	Lorien Nursing	Home				Columb		How	ard					
Funeral Director	577-07-8684	S. Sex 7. /	nge (In yrs. la 99		Under 1 Year Ionths Days	If Under 24 H Hours M	Irs. 8. Date of Bir (Month, Da Nov. 5	th ly, Year) 1900		e (State or Foreign Land				
2 2	Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Locat	ion				1404	Lineida Oib. Limite				
arya aho					ion				100	I. Inside City Limits  1 ☐ Yes 2 ☑ No				
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23e or	6500 Freetown R	oad #314			10f. Zip Code 21044			10g. Citizen of USA						
d within 72 hours after deeth with the Maryland glene. If the hedical Examiner must be notified at the Hedical Examiner must be notified at completed by Funeral Director.	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates	i? Mo		S Decedent of Hes, specify Cube		(Specify Yes or No erto Rican, etc.)	Ble	ce · American ock, White, etc by: White	2.				
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8047	20a. Method of Disposition  1 Burial 2\( \)Cremetion 3  4 Donation 5 Other (Spe		a Ce	ace of Disposition of Communication of C	ory or other place	•	Dete 11/18	Zoc. Location						
permit. Pag Department Important: I eny injury o	21. Signature of Funera) Service Licensee 22. Name end Address of Fecility													
the death certificate be executed  Whe attending physician and sched for use as the burtal-transit  hysician/Medical Examiner	23a. Pert1. Enter the disease, or o shock, or hear failure. List of limited and lisease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	a. Recur	Due to (or Due to (or Nur		to place on:  Dife	uem (us			, c	wills				
het the death certified by the attending detsched for use a Physician/Me	Part II. Other significant condition	d	but not resul	ting in the unde	rlying cause giv	en in Part I.		tobacco use co Yes 2□No		he cause of death				
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The lever the pege 2							10	Yes 2000	101	Yes 2 No				
certificate rector, per	25. Was case referred to medical					26. Placa of [	Deeth (Check only	one)						
	examiner?	Hospital:	tient 2 E	R/Outpatient	3 DOA Oth		g Home 5□ Resi		her (Specify)					
Attending Physic death.  ector: After this by the funeral d	27. Manner of Death  1 Matural 5 Pending 2 Accident investige	28a. Date of In (Month, D		28b. Time of Injury	28c. Injur Wor	y et k? Yes 2 □ No		how injury occu						
to a strending P at a strending P of Director. After the funer of in by the funer Certification:	3 Suicide 6 Could no 4 Homicide detarmin	ad 288. Place of I	njury - At hon etc. (Specify)	na, farm, street,	factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural F	Route Number,				
Hospit Puner fely fill	29a. Certifier 19 Certifying (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of axamination	ledge, death oc on and/or invest	curred at the tin igation, in my o	na, data and pla pinion, deeth oc	ace, end dua to tha courred et tha time,	causa(s) and m data end placa,	anner as state, and dua to th	ed. na causa(s)				
within 2 To the comple	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signe	ed (Month, De	ıy, Year)				
	> Sto fueros				D-74	1968		Nov 11	8,1559					
7	30. Name and address of person w	1055 LL	death (Item :	Pa-Tue	ir ac	Ca	lubio,	Mn ?	21044					
State	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	ire /										

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State of Maryland / Department of Health and Mental Hygiene 99 36262

					Certifica	ate of i	Death			Reg. No.						
Ph	ysician	Decedant's Nama (First, Middle, John	Anthony	1	Miller	Jı	^		2. Dete of De Month	Dey	Yaar	3. Time of De				
4.0	<b>Aedical</b>				TTTC.		120		Cation of Deeth		1999	3:00	PM			
Ex	aminer	4e Facility Name (If not institution, g				-										
		Saint Joseph				las d Vans	If Undar	DWSO				imore				
Fun	_		Sax 7. Ag	e (In yrs. lest birtl	Month	ler 1 Yaar s Deys	Hours	Min.	8. Dete of Birt (Month, Da	y, Year)	9. Birthp	laca (Steta or F	oreign			
Dire	ctor	218-28-9931	10 20 .	66 Y	rs.			7.44.	02/ 03	/ 1933	Mary	land				
P		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location						144	0d. Inside City I	Limite			
e Menyle	ctor	Maryland Harfo	rd	Bel Ai								1 ☐ Yas 2				
5-0020 72 hours efter death with the Meryland netural, or Herne 23a or 28s-f ahow	free must be notified Funeral Director	10e. Street end Number 1414 Redfield Rd	•			Zip Code I 015				10g. Citizen of 1	Whet Coun	iry?				
dea	5	11. Meritel Status	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Was Dec	cedent of H	ispanic Original	gin? (Spe	cify Yes or No Rican, etc.)	14. Rac	e - America					
21215-0020 d within 72 hours efter giene.	Examin by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		No		21 No	Specify:			Specif						
15-002 72 hours	Completed	15. Decedent's		16a. I	Decedant's Us	sual Occup	ation			16b. Kind of B	usiness/Ind	lustry				
vithin 7 within 7 within 7 than 'n	pie i	(Specify only highast ( Elementery/Secondery (0-12)	rede completed) College (1-4or 5		Give kind of vilte. DO NOT	vork done d use retired	during most I)	t of workin	ng							
212 3 within jene.	ф	7	Conege (1-401 :	Suj	perviso	or				Engin	eerin	g				
other		17. Father's Nema (First, Middla, La	st)				18. Mothe	r's Name	(First, Middle,	Maiden Sumer	10)					
₩ 0 € D	o Be	John Anth	ony	Miller	Sr.		Marga	aret								
Maryland  of 2 should be file  the end Mentel Hy  The merked othe	or other traumatic	19e. Informent's Name/Reletionship								er, City or Town		Code)				
	F	Regina W. Miller/ Spouse 1414 Redfield Rd. Bel Air, Maryland 21015														
Baltimore, Nomit. Pages 1 and Department of Heelth moorlant: If them 27	ŧ	20e. Method of Disposition		20b. Plece of cemetery	Disposition (A	ieme of r other piec	e)		Date	20c. Location	City or To	wn, Stete				
Baltimor permit. Pages Department of I	č	1 Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec						rdens	11/22	Timoni	ım Ma	rvland				
arte orte	any Injury	21. Signature of Funeral Service Lic	**	Durane		-	s of Fecilit		3 11/24	11110111	-					
W SOF	any l	KA . 0	1121	11-	David	J. We	eber 1	Funer	cal Hom	es P.A.						
_		Vava	* INN	ber	401 S.	Ches	ster !	St. I	Baltimo	re Mary	land	21231				
		23a. Part1. Enter the diseese, or shock, or heert failure. List	y one ceuse on each li	itha daath. Do ni ne.	ot anter tha m	oda of dyin	g, such es	cardiac o	r respiretory ei	rest,	1	Approximete Intervel Batwee	en			
Physic												Onset end Des				
/Medi Exami		nmediate Cause (Final seese or condition ISCHEMIC CARDIOMYOPATHY 2 YEAR'S														
LAGIII		resulting in deeth)	0.	Due to (or es e c	onsequence o	f):										
70	= = = = = = = = = = = = = = = = = = =										1					
orte	is the buriel-transit	Sequentially list conditions,														
9 . B	ē m	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying									i					
68760, rificete be ex		that initieted events	C	Due to (or es e co	nsequence of	D:					-					
	-	resulting in death) Last			,						i					
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O & &	ys Iche	Pert II. Other eignificant conditions			the underlying	ceuse giv	en in Pert I.			lobacco use co						
C to to	be detached for us by Physician	TYPE II DIABET	ES MELLITUS	5					10	Yee 20 No	3 Prot	oably 4 □ Un	IKNOWN			
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W 8	npi										of o	death?				
T of state	S S								10	res 200 No	1 🗆	Yes 22 No	5			
of Vital Physician: The this certificate	botor, pege 2 should Be Completed	25. Was cese referred to medical examiner?					26. Plece	of Deeth	(Check only o	ne)		1				
Of V Physic this ce	To	1 ☐ Yes 2 ☐ No	Hospitel: 1 Inpatie	nt 2 ER/Out	patient 3 1	DOA Oth	er: 4□ Nu	rsing Hon	ne 5 Resid	dence 6 □Oth	er (Specif)	1)				
g Phys		27. Menner of Deeth	28e. Dete of Inju (Month, De	ry 28b. Ti	me of jury	28c. Injun Worl	at	2	28d. Describe I	now injury occur	red					
O # # .	atio atio	1 Accident 5 Pending invastiget		, , , , , , , , , , , , , , , , , , , ,	M		Yes 2 1	No								
Division or Attending efter deeth. Director: After	led in by the funeral Certification:	3 Suicide 6 Could not determine	d 286. Piece of inju	ury - At home, fer	m, street, fect	ory, office		2		Street and Num	per or Rure	l Route Numbe	er.			
Dire de la la la la la la la la la la la la la	- La	4 Homicide	building, etc	c. (Specify)					City or Tov	vn, Stete)						
Division To the Hospital or Attending within 24 hours efter deeth. To the Funeral Director: After	completely filled in by the funeral director, page  Medical Certification: To Be Com		hysician: To the best of													
1 2 4 H	ed in	one)	end menner ste		o. m.vestigetti	, wriniy O		5050116								
To the	E CO	29b. Signatura and titla of certifiar			2	9c. License	number			29d. Date signe	d (Month,	Day, Year)				
		motion	111 1	lem -	m.r.	D195	508			now.	17.1	995				
2V/		30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print)										1,1717				
Chr.																
	State	31. Dete filed (Month, Dey, Year)	DELEON M 32. Registr	D. 760 ar's Signature	ir nar	- T	VIZTAE	. []	MODIA	TIMIN I book	1:41/ E	s als been No. 1				
Rei	State pistrar	NOV 1		apara	D	1000	Ken	,								

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miller John Anthony JR

NOV1:34

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	·-···				Certificate of	of Death	Re	g. No.	36263					
	Physic /Medi		1. Decedent's Neme (First, Middle, Le  Manie	si) McKe	ldin		2. Dete of Deeti	Dey 1999	3. Time of Death 7:15A.M.					
	Exami		4a. Fecility Neme (If not Institution, giv Ridgeway Manor Nu			4b. City, Town, or L Baltimore		4c. County of Death Baltimo:						
	Funeral Director		210-07-3174	Sex 7. Age (In yrs. 88	Yrs. If Under 1 Ye Months De	er If Under 24 Hrs.	6. Dete of Birth (Month, Day OCT. 18	Year) 9. Birth	pplece (State or Foreign intry) yland					
	Maryland I-f show	tor	Usuel Residence of Decedent  10e. Stete Maryland Baltimo	re City 10c. City	y, Town or Location Balti	more City			10d. Inside City Limits 1 Yes 2 □ No					
	th with the	al Director	10e. Street end Number 4208 Kenwood Aven	ue	10f. Zip Cod	21206	10	Og. Citizen of Whet Cou USA	untry?					
020	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, The Medical Examiner must be notified at	by Funeral	11. Maritel Stetus  1 Never Merrled 2 Married  3 Nowidowed 4 Divorced	12. Wes Decedent Ever In U, Armed Forces? 1 □ Yes 2 ☑ No If Yes, Givê A Yeer or Detes:	S. 13. Wes Decedent If Yes, specify C	of Hispenic Origin? (Sp cuben, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Bleck, White Specify:						
Maryland 21215-0020	d within 72 ho piena. r than "natur the Medical	Completed by	15. Decedent's E. (Specify only highest grade Elementery/Secondery (0-12) 12 yrs.	ducation ade com <i>pleted)</i> College (1-4or 5+) N/A	16a. Decedent's Usuel Oc (Give kind of work do life. DO NOT use re Secretary/Su			16b. Kind of Business/lendix Compa						
yland;	2 should be filed withingend Mental Hygiena. Is marked other than aumatic event, the Mental Control of the Men	To Be C	17. Fether's Neme (First, Middle, Last, William Segrist		, , , , , ,	18. Mother's Nem			,					
	ges 1 and 2 sho t of Heaith end If them 27 is ma or other traums		James A. Segrist 20e, Method of Disposition	20b. P	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip  134 Lyndale Avenue Baltimore, Md. 21236  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Gardens of Faith Cemetery 11–20–99 Baltimore,									
Baltimore,	permit. Pages 1 and Department of Heaith Important: If hem 27 any Injury or other tr	1 8	X Burial 2 Cremetion 3 C 4 Donation 5 Other (Specification 21. Signature of Funeral Service Ligar	Gar	dens of Faith			Baltimore	, Maryland					
8	8255		on part that the reference or	plinations that havened the death	7401 Bel	air Rd. Ba	ltimore.	Maryland	21236					
	Physician /Medical Examiner		Immediate Ceuse (Finel disease or conditions or condition resulting in death)	one ceyse on each line.	O- Reel T				Approximete Intervel Between Onset end Deeth					
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	n/Medicai Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	. 001	as a consequence of):									
P.O. B	t the d by the tached	Physician/M	Pert II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying cause	given in Pert I.	23b. Did tol		to the cause of death?					
Records,	BW 2 S	Completed by					24a. Wes er perform	ned? e	Vere eutopsy findings veileble prior to ompletion of cause f deeth?					
Vital R	Pe ata		25. Wes case referred to medical			Of Disease Manual	1 ☐ Ye		☐ Yee 2☐ No					
ō	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	ation: To Be	examiner?  1  Yes 2 No  27. Menper of Deeth  1 Netural 5 Pending investigation investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of linjury 28c. In	Othor	ath (Check only one)  Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred							
Division	ital or Atterned and Directorial Directorial	Certification:	3 ☐ Suicide 4 ☐ Homicide  28e. Pleca of Injury - At home, farm, street, fectory, offica building, efc. (Specify)  28e. Pleca of Injury - At home, farm, street, fectory, offica building, efc. (Specify)  28f. Location (Street end Number or Rural Route Number, City or Town, Stele)											
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29e. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinet end manner steted.	wledge, deeth occurred et the ion end/or Investigetion, in m	e time, dete end pieca, ny opinion, deeth occur	end due to the ce red et the time, da	use(s) end manner es ite end place, end due	steted. to the cause(s)					
	Tot Tot	×	29b. Signeture end title of certifier	, n.D.	29c-tiq	ense number	528 25	d. Date signed (Month	pan Years					
	9		30 Name and address of derson who	completed cause of death (Item	524 (Type, Priot) Col	Fred	vice	CKORI						
	Sta Registr	-	31. Date filed (Month, Dey, Year)	32. Registre & Signal	souls)	2100								

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State of Maryland / Department of Health and Mental Hygiene 99

36264

					Cei	uncale	OI	Death			Reg. No.			
nysician Medical	1. Decedent's Name (Fire William Me	enn								2. Dete of Month	Day ER 17,		3. Time of Death 24:25 P	
xaminer	4e Fecility Neme (# not it				de man		- 1		own, or L	ocation of De	ath 4c. Cour	nty of Death Balti	PR 45 45 45	
eral	5. Social Security Number		Sax	7. Aga (In yrs.		If Undar 1	Yaar	If Undar		8 Date of I	Birth			
	219-01-1650 Usual Residence of Dece		NOXM 2□ F	91		Months	Deys	Hours	Min.	(Month,	Dey, Year) 14,1908	Germa	ce (State or Foraign y) ny	
		County		10c. Ci	ty, Town or Lo	cation						100	d. Insida City Limits	
Director	Maryland B.	altimo	re	Hal	ethorp	e 10f. Zip 0	ada				100 Citizen	of What Country	1 ☐ Yas 2 ☑ No	
	1726 Winan	Δυρη	110				227	7				State		
Funeral	11. Merital Status	214 611	12. Was Dad	edent Evar in U	J,S. 13. \				igin? (Sp	pecify Yas or I		aca - Amaricar	n Indian,	
5	1 Nevar Married 2 3 Widowed 4 D		Armed F 1 Yes If Yas, G Yaar or I	2K No		r Yes, specii I⊡ Yes 2∫		Specity:		Hican, atc.)		leck, Whita, at White		
2010	15. E	ecedent's E	ducation ada complated	)	16a. Deced	lent's Usual kind of work	Occup	ation	t of work	cina		Businass/Indu		
Completed	Elementery/Secondary			(1-4or 5+)	lifa. l	DO NOT use	ratired	1)	t or worn	9				
3	12 17. Father's Name (First,	A distable 1 and	45		Baker			40 Mark	ada Alaas	- /Fina Adida	Bakery			
10 56	Williams Lo										Ma, Meidan Sum aulina I			
	19a. Informant's Name/F Maxine M. M					-					nbar, City or Tow e, MD 21		iode)	
21.  23.  Chysician /Medical Examiner Jack Bridge Section (1988)	20a. Mathod of Disposition	1			Place of Dispo camatary, cran	sition (Name	of ar pled	<b>&gt;e)</b>	1	Dete	20c. Location	n - City or Tow	n, Stata	
	21. Signetura of Funaral Sarvica Licensaa  22. Nama and Addrass of Facility  Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus, MD 21227													
	23a. Part1. Enter tha dis	MI		xan y									227 Approximata	
	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disasse or Injury that initiated events resulting in death) Last	s.	b		Dua to (or as a consequance of):  Dua to (or as a consequance of):									
	D	4144									1445			
by Physician	Part II. Other significant RENAL FAI		contributing to c	seath out not ras	suring in tha ui	ndenying car	ise giv	en in Pen			□ Yes No		the cause of death?	
Completed b	CORONARY ARTERY DISEASE									24a. W	as an eutopsy normed?	avail	a autopsy findings labla prior to plation of cause eath?	
mo.										10	yes 2₺No	10	Yas 2 No	
Be	25. Was casa rafarred to	••				of Dee	th (Check on	y ona)						
tea or Attending Physics at a state of Attending Physics at a state of the correct After this of led in by the funeral director. To Certification: To	1 ☐ Yas 2 ☑ No		43		ER/Outpatien			4 U NI	ursing Ho		asidenca 6 🗆 C			
	2 Accident	Panding invastigatio	28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?						No	28d. Dascrib	e how injury occ	urred		
	3 Suicida 4 Homicida  6 Could not be determined  28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)											n (Street and Nu Town, Stete)	mber or Rural i	Routa Number,
	29a. Certifiar (Check only one)	ertifying Ph edical Exar	miner: On tha t	e best of my kno basis of examine	owledge, deeth	occurred et	the tin	ne, date en pinion, des	nd place, ath occur	and due to the	na cause(s) and a, data end plec	menner es stat e, end dua to t	ted. ha cause(s)	
Me	29b. Signature and titla of certifier  29c. License number  29d. Data signad (Month, Day, Year)  11-17-99											By, Year)		
	30. Nama and addrass of	person who	complated cau	sa of death (Iter	n 23a) (Type	-		ten to trol					/	
0	FRANCIS H				OSLER		E	TOWS	ON,	MARY	LAND 2	1204		
	31. Dete filed (Month, Da			Registrar's Sign	eture	4	1	~						
	11	JV 1 9	נכנו	porter		19	00	K						

MENN, WILLIAM

NOV 1 8 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Deta of Death Month 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death Day **Physician** Gertrude Born Nesterenko September 24, 1999 2:45 p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 4016 Born Road Jarrettsville Harford tf Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 XF 213-16-4025 Yrs 93 Director Nov. 5, 1905 Germany Usual Rasidance of Decedant 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits natural, or lients 23s or 25s-f show MD Harford Jarrettsville 1 ☐ Yas TYNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4016 Born Road 21084 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Merital Status Black White etc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married aitimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White 3 ☑ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filed within Elementary/Secondery (0-12) Hygiene. Collega (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be h and Mental h Pages 1 and 2 should be 10 Konrad Born Amanda Kerst 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Ilma Rosskopf 2422 Pellham Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 Burial ZX Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) Baltimore Washington Cr. 11/11/99 Laurel, Maryland 22. Nama end Addrass of Facility Fleck Funeral Home, Inc. 21. Signature of Funaral Sarvice Licensea 7601 Sandy Spring Road, Laurel, MD 20707 Anatomical Gift Foundation 23a. Part 1. Entar tha disaasa, or compike from the caused the shock, or heart failura. List only one ceuse on each line. laath. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, Approximate Intarval Between Onset end Death Physician Cerebrovosantar wo wieks /Medical Immediate Cause (Final disaasa or condition Examiner Examiner that the death certificate be executed physician and s the bunal-trens Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or Injury that initieted events rasulting In death) Last Dua to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as e consequence ot): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, I þ 24b. Were eutopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No certificete To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, g Be 25. Was case retarred to medical axaminar? 26. Placa of Death (Check only one) axaminar? 1 ☐ Yes 2 No Hospital: 1 tnpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) edical Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of De 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Panding Investigation 1 Yas 2 No 6 Could not be datarmined 28a. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the course of the time, date and place, and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and place and due to the course of the time, date and due to the course of the time, date and due to the course of the time, date and due to the course of the time. 29a. Certifier Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifian 29c. License number 30. Nama and addrass of person who completed ceuse ot death (Itam 23a) (Type, Print) 1 Air Muryland 21014 6 2 North Aunions H61W11) 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 9 1999

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NOV 1 9 1999

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e of L	Death			Reg. N	10.	J	6266	)
1.1.0	Physician	1. Decedent's Neme									2. Dete of D		ev Y	'ear	3. Time of Dea	ath
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	Examine	An Facility Name ///	not institution, give	are Hos	pital	Ce	nte	n 4	R	osed	dale	th 4	c. County of Bal-	Deeth	none	
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J. 200	and 21/215-0020 be filed within 72 hours efter and other than "naturet, or its c event, the lead of Furnita	3 ☐ Widowed	od 2⊠ Married	12. Wes Decedent Armed Forces? 1  Yes 2  If Yes, Give Yeer or Dates:	,	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - /								White, e		
7/5		(Speci	15. Decedent's Ed fy only highest gra	de completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business								ness/Indu	ıstry	
Min		Elementery/Secon	idery (0-12) t h	College (1-4or	5+)		emak						In ow	n h	ome	
Syland		17. Fether's Neme (	17. Fether's Neme (First, Middle, Last)  Henry C. Wise  Mary Garrett  Mary Garrett													
Mary	1 and 2 should Health end Men marke mm 27 le marke ther treumatic	19a. Informent's Name/Relationship (Type, Print) spouse Mr. Jack Owensby Jr.  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Z 113 Margaret Avenue, Baltimore, Md														
Oh.	Pages 1 an nent of Heal int: if itam 2 iry or other			Removel from State	Cei	ece of Dispo metery, cret klawr	netory or o	ne of other place	9)	11	Dete / 19/9		Location - Ci		<sub>vn, Stete</sub> Marylan	ıd
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within 24 hours effer deeth.

To the Funerel Director: After this certificate has been signed by the at completaly filled in by the funeral director, page 2 should be detached for Physici Be Completed by

Division of Vital Records, P.O. I

To the Hospital or Attending Physician: The lew requires that the des

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy parformed? 2 X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. tnjury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29a. Certifier 29b. Signature and thie of certifie 29c. License number

State Registrar

29d. Date signed (Month, Day, Year)

36266

30. Neme end eddress of parson who completed cause of death (Item 23e) (Type, Print)

9000 Frank

31. Dete filed (Month, Day, Year)

9 1999

32. Registrar's Signatu

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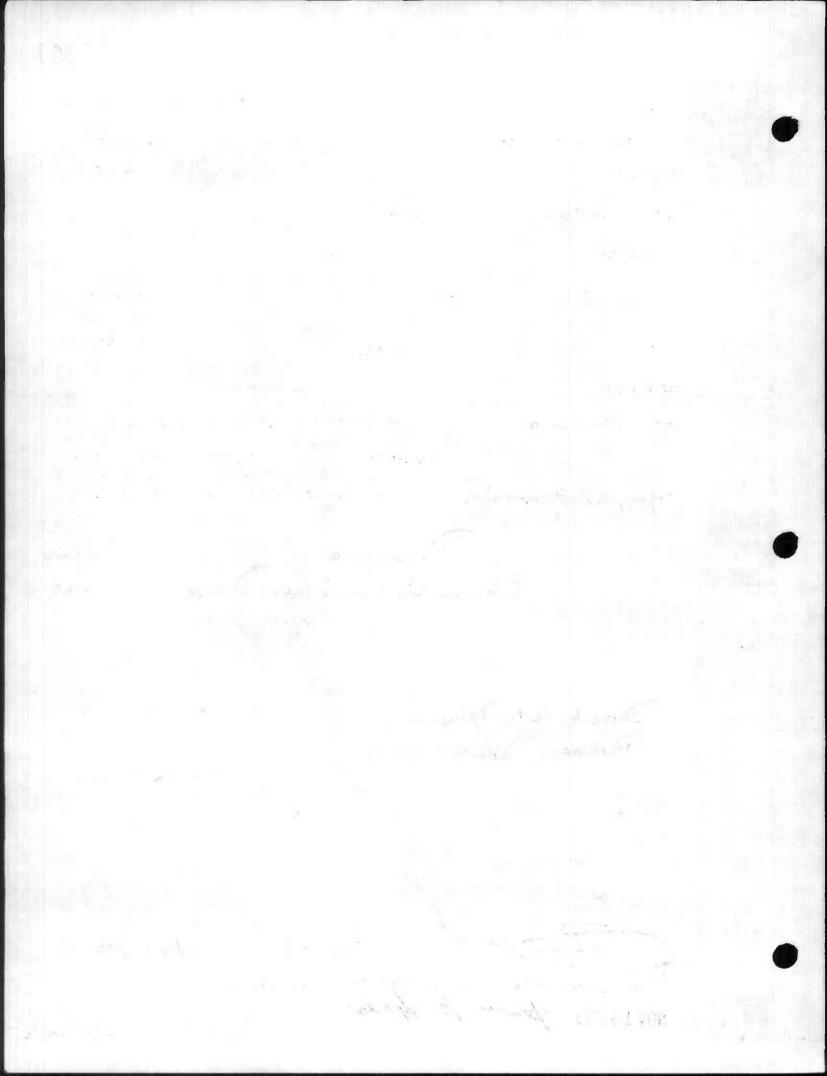
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State of Maryland / Department of Health and Mental Hygiene 99 36267 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death November 1 1999 **Physician** 18 10:00am Willie Runvon /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, giva street and number) Examiner Meredian Brightwood Nursing Home Lutherville Baltimore If Under 1 Yaar | if Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Stata or Foreign Country) West Virginia 5. Social Security Numbar 7. Aga (In yrs. last birthday) **Funeral** 11X M 2□ F Months Yrs. Director 235-22-8658 6-17-1923 76 Usuel Residence of Decedent with the Maryland 10d. Insida City Limits 10a State 10b. County 10c. City. Town or Location r than "natural", or itema 23a or 28a-f show the Medical Exampler must be notified at MD Baltimore Lutherville 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 12 Brookfield Garth 21093 LISA Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Black, White, etc. 1 X Yas 2 No If Yes, Give W Year or Datas: 1 ☐ Never Married 21X Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Public Service Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed will Department of Haalth and Mental Hygian important: if item 27 Is marked other that eny Injury or other traumatic event, that once. Executive 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Floyd Runyon Leodie Hensley 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Spouse 12 Brookfield Garth, Lutherville, Maryland 21093 Partricia (Little) Runyon 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State Greenmount Cemetery 11/22/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Joseph N. Zannino Jr. Funeral Home 21. Signature of Funeral Service Licensee 263 S. Conkling Street, Baltimore, Maryland 21224 e or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, List only one ceuse on eech line. tl. Enter the diseese, Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Neumon.a 1-2 als Examiner Due to (or es e consequence of): Examiner Isease cars sician and burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Lest Due to (or as a consequence of) Box 68760, attanding physician Physician/Medical Dua to (or as a consaguance of): the SB ata has been signed by tha a paga 2 should be datached t Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. to Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy cartificata has 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: aftar death. Director: Aftar this cartifica 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurrad Certification: 27. Menner of Deeth 28b. Time of 5 Pending Injury 1 DNaturel 1 Yes 2 No invastigation 2 Accident tha 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) complataly filled in by 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medicel Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to tha cause(s) Medical (Check only and mannar statad. To the Vithin 2 29d. Date signed (Month, Dey, Year) 29b. Signatus 29c. License number Assending Nov 18 (30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 115 E. Melrose shwARtzMD. 32. Registrar's Signatura 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

NOV 1 9 1999



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State of Maryland / Department of Health and Mental Hygiene QQ 26269

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	Examine	4.0	Facility Nama (//							4b. City, To	own, or Lo	ocation of Deal		County of E	Death				
			BAYVIEW	HOSPITAI									CITY		N/A				
	Funeral Director		Social Security No. 217-14-09		Sex 1 □ M 2 🂢 F	7. Aga (In	yrs. last birtl	hday)_ 'rs.	If Under Months	1 Yaar Days		24 Hrs. Min.	8. Data of Bi (Month, D JUNE 2	irth lay, Year) 23.19			ace (Stata or Foraig ry) (LAND	n	
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	and 2 alth e	M	MRS. NAOMI M. WOLF (Sister 3707 INA AVENUE, BA								BALTI	MORE,	MARYA	LND 2	2120	6			
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Baltimore,	Department Department Important: any Injury once.	2	1. Signatura of Fun	aral Sarvice Lice	nsee			22.			ass of Facil	ity			111010		HIN L LIMID		
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MONTH SECTION

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 36269

				,	Cer	tificate (	of Death		Reg. No.	30203	
		Decedant's Nama (First, Middle, Last)					2. Data of De Month	ath	3. Tima of Death		
Physici /Medic		Thomas Schultz						Novemb	er 18.	1999 3:00 a.m.	
Examir							4b. City, Town, or	Location of Death			
		Mariner Health of	E Kensingt	on			Kensing	rton	Mont	gomery	
Funeral		5. Social Sacurity Number 6. S	ax 7. A	ga (In yrs. le	ast birthday)	If Under 1 Y	ear If Under 24 Hr	8. Date of Birt	th	9. Birthplace (State or Foreign	
Director									Washington, Do		
show at a	'n	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits  M∑Yas 2 □ No	
the N	Director	MD Montgomery Kensington  10e. Street and Number 10f. Zip Code							10g. Citizen of W		
ath with the Merylan s 23s or 28s-f show		3000 McComas Avenue 20895							rial Country?		
ar da Herne	Be Completed by Funeral	1. Marital Status    \times \int \int \int \int \int \int \int \int			13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerlo 1 Yes 2\times YNo Specify:			Specify Yes or No to Rican, etc.)	y Yes or No- an, etc.)  14. Race - American Indian, Black, White, atc.  Specify: White		
72 hours		15. Decedant's Ec	lucation de completed)		16a. Decede	6a. Decedent's Usual Occupation (Give kind of work done during most of wo		16b. Kind of f		Business/Industry	
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nd 2121 e filed within al Hygiene. i other than vent, tre		0 0				Disabled					
Maryla		17. Fathar's Nama (First, Middla, Last)		18. Mother's Nama (First, M.							
	2	William J. Schult				1000			E. Rice		
		19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Rou									
		Cathy Rosenberger	7/Sister	001 01			Lane, Lau				
Baltimore, semit. Pagas 1 at Department of Has moorbatt if Nem in y Injury or other in to the interest.		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐	Ramoval from Stata	000	ace of Dispos metery, crem	atory or other	place)	Date	20c. Location -	City or Town, Stata	
permit. Paga: Department of Important: If if eny Injury or page.		4 ☐ Donation 5 ☐ Othar (Specific	y)	Baltimore Washington Cr.				11/19 Laurel, Maryland			
Physician	4	21. Signature of Funeral Dervice Ligansee  22. Name and Address of Facility Fleck Funeral Home, Inc.  7601 Sandy Spring Road, Laure1, Maryland 20707  23a Part Enter Mordiseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Interval Between Onset and Death  Approximate Interval Between Onset and Death									
/ /Medical Examiner		Immediata Causa (Final disaasa or condition resulting in daath)	a. Septicemia  Dua to (or as a consequence of):							Days	
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68/60, tificate be executed g physicien and es the buriel-transit	ledic	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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the of the period	ysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobecco use contribute to the cause of death?			
S, T	by Physician/N	Mental Retardation; Recurrent Aspiration;						1 Yes 2 No 3 Probably 4 Unknown		3 Probably 4 Unknown	
aw raquir as been s 2 should	Completed	Pneumonia; Multip	nomalies				an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?			
= F # a	5							10	Yes 2 No	1 ☐ Yes 2 ☐ No	
To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Be	25. Was case raferred to medical axaminar?	26. Place of Death (Check only one)								
	2	1 Yas 2 X No	Hospital: 1 ☐ Inpati	ant 2 E	ER/Outpatient 3LI DOA		Other: 4 Nursing	Home 5 Resid	tome 5 Residence 6 Other (Specify)		
		27. Mannar of Death 1 XNatural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Data of Inju (Month, Da	8b. Time of Injury at Work?  M 1 Yes		Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		ed		
	Certification:	3 Suicida 6 Could not be determined	jury - At hor lc. (Specify)					f. Location (Street and Number or Rural Route Number, City or Town, State)			
	edical	29a. Certifier (Check only one)  1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
Vithin To the comp	Me	29b. Signature and title of cartiflar 29c. License number							29d. Data signed (Month, Day, Year)		
1		Martin C Thayel W D08944							11/18/1999		
- 1		30. Nama and addrass of person who complated causa of the (Nem 23a) (Type, Print)  Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895									
0.	40	Martin C. Shargel 31. Data filed (Month, Day, Year)		rar's Signatu	arragu	L Aven	ue, Kensir	igton, Ma	ryland	20895	
Sta Registr		NOV 1 9 1999	Severe	19	Apa	de					

NOV 1 8 1999 James & Santa

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 AMENDED ITEM #5 PER FH G777 11/19/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Thornton November 18, 1999 1:00pm /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10 Valley Frost Court, apt. G Cockeysville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 550-07-4282 550-07-4782 Birthplace (State or Foreign Country) **Funeral** Days 1□M 257F Months 95 Director March 17,1904 Germany Usual Residence of Deceden r 28e-f show 10b, County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Directo Maryland | Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pegas 1 and 2 should be filed within 72 hours effer death with 1 and 1 death by Jane.
Int: if item 27 is marked other than natural, or items 23a or 1 any or other traumete event, the feature from that in yor other traumete event, the feature from that in yor other traumete event, the feature from that is not of the feature from that it is not other traumeters. 10 Valley Frost Court, apt. G 21030 Funeral USA 12. Wes Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Homemaker Own Home unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Martha Maria Schmidt 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 F. Cinnamon Ridge Place, Cockeysville, MD 21030 Myrtle Badger/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/19/99 1 ☐ Burial 2 MCremetion 3 ☐ Removal from Stete permit. Pega Department of Important: if eny Injury or paca. 4 Donation 5 Other (Specify) Baltimore-Washington Crematory Laurel, Maryland 21. Signature of Funeral Service Liceology 22. Neme end Address of Fecility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Entgr the disease, or complications that shock, or bear failure. List only one cause on Approximete Interval Between **Onset end Death Physician** Myc cardial Intarction Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner physician and the buriel-transit the deeth certificate be specuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☒ No of Vitai 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation or Attending 1 Netural
2 Accident after death. Director: Aft d in by the fur 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)30910 December 19, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Stoltz, MD 1447 York Road, suite 605, Lutherville, MD

Registrar

State

**NOV 19** 

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 3 6 2 7 1

		Decedent's Nama (First, Middle, Last)				Cel	rtificat	e oi	Dealli	2. Data of D	Reg. No. 2. Data of Death		3. Tima of Death	
Physic			G. Tichr							Month	Day	Year 1999		
/Med		4a Facility Name (			ber)				4b. City, Town, o	NOVEMB r Location of Dea		1999 ty of Death	1:30 AM	
Exam	ner	SAME AND AND AND	HOSPITA						CUMBERLA			EGANY		
Funera		5. Social Security			. Age (In yrs.	last birthday)	If Under		If Under 24 Hr	s. 8. Date of B			plece (State or Foraign	
Director		214-05-	-7925	1□M 2X)F		85 Yrs.	Months	Days	Hours Mir	Mayoning b	ay, 1 9 a 1 / 4	Cou	utry) MD	
9	М	Usual Residence of	_		40.00	-								
eho-	-	10a. State	10b. County	ah amir		y, Town or Lo Cumber							1 ☐ Yes 2 No	
he M	ecto	MD 10e. Street and Nu		gheny		Cumber	_	0-4-			40+ Chi	()MP-at Carr		
23a of	Funeral Director		e Street				10f. Zip		21502	oř. T	10g. Citizen o	USA		
d 21215-0020 filed within 72 hours effer death with the Meryland bygiena. ther than "natural", or florns 23s or 23s-f show ont, the Merical Espanse must be notified as	þ	11. Marital Status 1 ☐ Never Men 3 X Widowed	ried 2 Merried 4 Divorced	12. Wes Deced Armed Ford 1 Tes 2 If Yes, Give Yeer or De	es? 2 No XX		Wes Deced If Yes, spec 1 Yes		of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indien, Bleck, White, etc.  Specify: White				etc.	
aryland 21215-0020 should be filed within 72 hours of and Mental hygiena. marked other than "natural", or marke event, the Menter Eram	Completed	(Spe Elementary/Secr 1.2	15. Decedent's E cify only highest gro ondary (0-12)	ducation ade completed) College (1-	for 5+)	/Giva	DO NOT us	rk done se retire	during most of w	orking	16b. Kind of		home	
and 212 be filed withintel Hyglene. d other than		17. Father's Nama	(First, Middle, Las	)				1040	_	eme (First, Middle	e, Maiden Sumi		Home	
ylan Mental Mental arked o	To Be	Marcus	W. Volk						un	known				
Maryland d 2 should be file th and Mental Hy 7 is marked other traumatic event	-	19a. Informant's Name/Relationship (Type, Print)  Mary G. Dedera/daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or To 9220 West San Miguel, Glendale,							n, State, Zip	o Code)				
1 and 2 : Health ar em 27 la		Mary G	. Dedera/	daughter	bres.	92	20 We	est	San Migu	el, Gler	ndale, A	AZ 85	305	
T it of He		4 ☑ Donation	☐ Cremetion 3 ☐ 5 ☐ Other (Speci	(y)	tete	lace of Dispo emetery, crea	sition (Nam matory or o	ne of other pla	ace)	Date	20c. Location	n - City or To	own, Stete	
Baiting Parties Important: eny injury once.		21. Signature of F	uneral Service Lice ROTAL d	S. Wade	, Direc	tor 2				pard 655 21201	W. Bal	timor	e Street	
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/ /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	e. INTRA	CRANIAI			E	8			1	24 HOURS	
D #	Je l	Due to (or es e consequence of):  RESPIRATORY FAILURE									i i	24 HOURS		
acute and -trans	Examiner	Sequentially list co	onditions,	0		r es e consec								
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58760, cate be asscuted physician end s the buriel-transit	edical	that initiated event resulting in death)	S Last			as a conseq	uence of):				2-10000			
ding sees				d THROM	BOCYTOR	PENIA							24 HOURS	
BOX seth cert attendin for use	clan				2.14							- 1		
P.O.	Physician/N	Part II. Other signi	ficant conditions	contributing to dea	th but not resi	ulting In the u	nderlying c	ause gi	ven in Part I.				o the cause of death?	
deta deta	Y P									_ 1L	Yes 2□ No	3 ☐ Pro	bably 4 Unknow	
I Records, P.O. Box 68760,  The law requires that the deeth certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	Completed by			8	Hales						s an autopsy formed?	8/	Vare eutopsy lindings vailable prior to projection of cause	
The lever ate hes pege 2	d L										. V.		death?	
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Of Vita Physician: this cartific	o Be	25. Wes case reference examiner?		Hospitel:	nationt O	EB/Outpation	a 2□ 00	Ot Ot	har	eath (Check only		wher /Cnesi	6.1	
	- I	27. Magher of Dear	1	28a. Dete of (Month	1) Inpatient 2 ER/Outpatient 3 DOA			8c. Inju	Other: 4 Nursing Home 5 Residence 6 Other (Special North Property of Property			ny)		
Division at or Attending s after death. It Director: Afte	Certification:	Accident arrestigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location City or To	(Street and Nur own, State)	nber or Rur	al Route Number,	
To the Hospital within 24 hours a To the Funeral Completaly filled	edical	29a. Certifier (Check only one)	Certifying Pt	nysician: To the b niner: On the bas end manne	is of examine									
To the To the comp	Z	29b. Signature and	title of certifier	/ ,	0		290	. Licen	se number		29d. Date sign	ned (Month,	Dey, Year)	
		Dan	le /	rd	1		I	D 55	5079		NOVEMBE	R 9.	1999	
		30. Name and add	ress of persual who	completed cause	of with (Item	23a) (Type,								
		DR. PAUL	A WADDY,	47 VIRGI	NEA AV	ENUE,	CUMBE	ERLA	ND, MD	2150	2			
		31. Date filed (Mon	th, Day, Year)	32. Re	gistrar's Signa	tura		- 1						

Registrar **DHMH 16 Rev 6/95** 

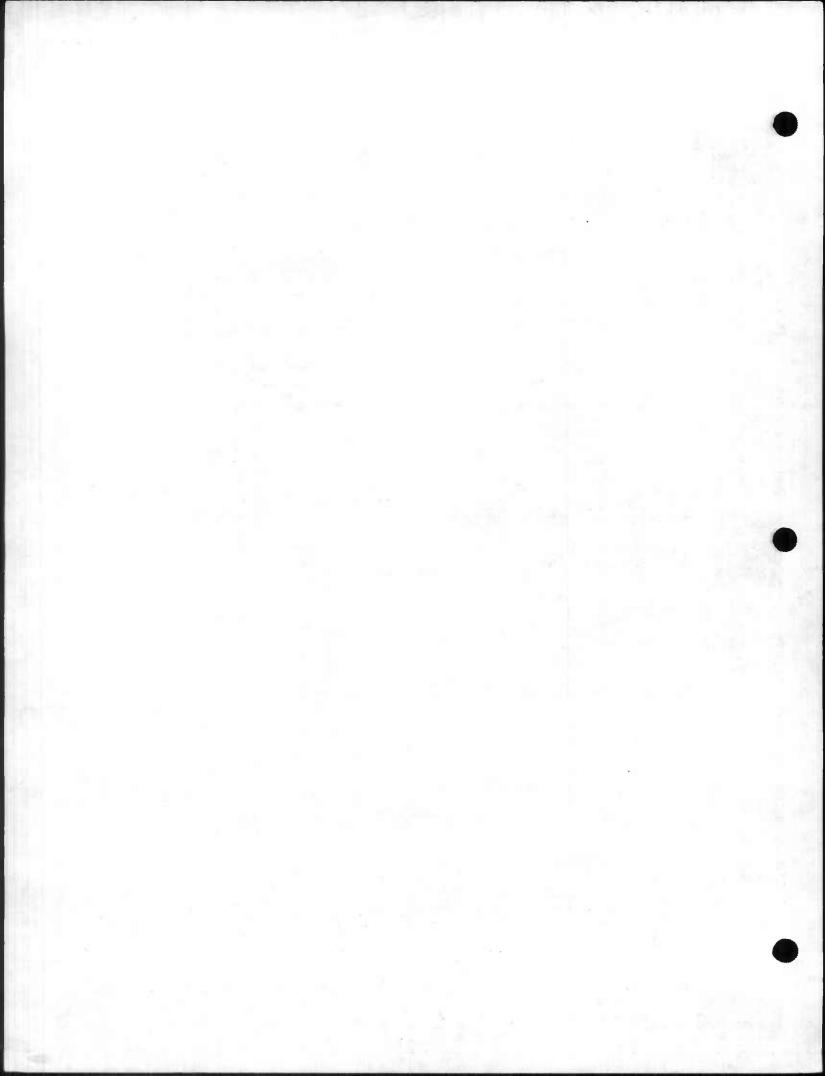
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31. Dete tiled (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36273 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HOMPSON GRE-**Physician** NO 8:30 a.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year 6. Sex If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F 87 Director 578-16-2248 April 17, 1912 Washington, DC Usual Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan neat of Health and Mental Hygiena.
Int: If item 27 is marked other than "natural", or items 23a or 28a-1 show any or other than "natural", or items 20a or 28a-1 show any or other traumatic event, the Medical Esterics man to notified at any or other traumatic event, the Medical Esterics man to notified at 1XXYas 2 No Director Maryland Prince George Laurel 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 13913 Briarwood Drive #121 20708 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No 1f Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien. 11. Meritel Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White g 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk US Government 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Henry Lorleberg Margaret Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 13913 Briarwood Drive #121, Laurel, Maryland 20708 Vincent E. Thompson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Important: If any injury or page. Cedar Hill Cemetery 11/15/99 Suitland, Maryland 22. Nama and Addrass of Facility 21. Signature of Funeral \$ Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 erry Entar the draase, or complications that caused the death. Do not entar tha mode of dying, such es cardiac or raspiratory errast, or hapfi failura. List only ona cause on aach line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaase or condition rasulting in deeth) /Medical Condid Vascular week Examiner Physician/Medical Examiner iclan and burial-transit Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Diseese or Injury that initieted evants rasulting in death) Last Due to (or es a consequence of) Box 68760, physician s the burial The law requires that the death certificate be Due to (or es e consequence of): Se P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 donknown Records. g page 2 should b 24b. Ware eutopsy findings evailabla prior to complation of cause of death? Completed 24a. Was an autopsy parformed? 1 Yas 2 No 1 Yes 2 No of Vital Physician: funeral director, Be 25. Was case referred to medical axaminar? 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 ☐ Yas 2 ☐ Ño 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? After Division or Attending 5 Pending invastigation i Director: Aft of in by the fur 1 Yas 2 No 2 Accidant 6 ☐ Could not be determined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifian (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura end titla of certifier 30. Name and eddrass of person who completed causa of death (flem 23a) (Type, Print) 542 5450 4333 James Laurel 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura State NOV 1 9 1999 Registrar

DHMH 16 Rev 6/95

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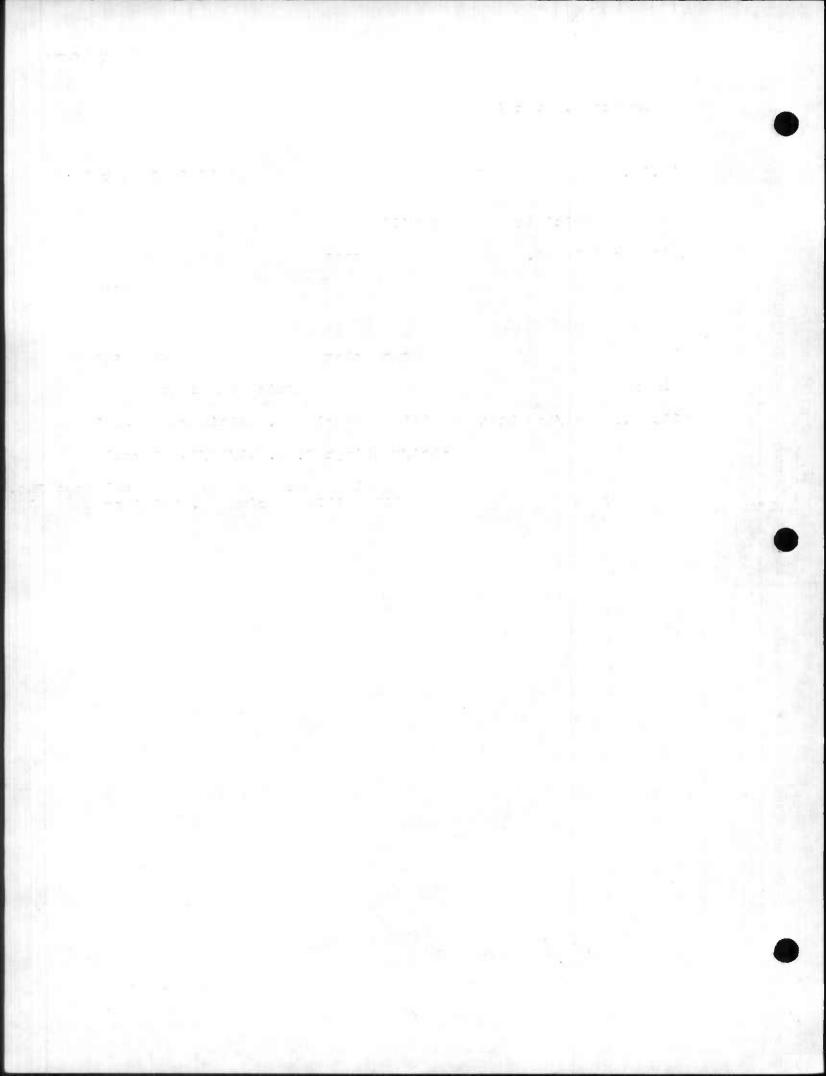
State Registrar **DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

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32. Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day **Physician** Mar ass 3: 20 PM 11 12 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner lepional Prince George Laurel Mospital Laurel 5. Social Security Number 7. Aga (In yrs. last birthday) 65 Yrs. If Under 24 Hrs. 8. Dala of Birth (Month, Day, Yaar)
Jan. 19, 1934 9. Birthplaca (Stata or Foreign If Undar 1 Yaar **Funeral** Months 10 M 20 F Days Min Hours Jan. Washington, DC 579-42-6977 Director Usual Rasidence of Dacedani the Meryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mourcal Examinar must be notified at 1 ☐ Yas 2 No Director MD Howard Savage 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 72 hours efter death with 8329 Woodward Street 20763 USA Funeral 12. Was Decedani Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Year or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Navar Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours eft. Department of Health and Mental Hygiene. Introcramt: If Item 27 is marked other than "natural", or hany injury or other traumatic event, the traumatic ovent. 1 Yas 2 No Specify: Specify: White by 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) College (1-4or 5+) Elementery/Secondary (0-12) Waitress Restaurant 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Nama (First, Middla, Last) Tony Piscitelli Francis Lillian King 19b. Meiling Addrass (Street and Number or Rurel Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Box 334, Haymarket, Virginia 20168 Thomas Vass/Son 20b. Placa of Disposition (Neme of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Stonewall Memory Gardens 11/16 Manassas. Virginia 22. Nama and Addrass of Facility 21. Signatura of Funeral Sarvice Licensas Fleck Funeral Home, Inc. 23a. Part 1. Enjegitha disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, Intervel Between Onsat and Death **Physician** ANTREW SYNMOME /Medical Immediate Cause (Final 3WEENS diseese or condition resulting in daath) Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate ceusa. Entar Undarlying Causa (Diseasa or injury that initiated avants rasulting in death) Lasl Division of Vital Records, P.O. Box 68760, 11 attending physician Physician/Medical the signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PNOWMOWIA, SEPSIS NIABETEN METLITU 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Wara autopsy findings available prior to 24e. Was an autopsy performed? RANAI INSUFFICIANCY complation of cause of daath? hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificete To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical funerel director, Be 25. Was cesa rafarred to medical axaminar? 26. Plece of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2D No 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Daath 28b. Time of 28d. Dascribe how injury occurred 28c. injury at Work? 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straet, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the ceuse(s) and mannar es stated. edical er: On the basis of axaminetion and/or investigation, in my opinion, daath occurred et the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 2 Medical Exami 29b. Signatura and 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Nema and edd who complated ceusa of deeth (Itam 23e) (Type, Print) LAUNTI 32 6 FOIL E 32. Registrar's Signatura State Registrar

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State Registrar

DHMH 16 Rev 6/95

31. Date filed (Worth, Dey, Year)

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32. Registrar's Signature

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30. Name and edd ess of person who completed cause of death (Item 23a) (Type, Print)

p pala

111 Penn Street, Baltimore, Maryland 21201

**ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Stella Rose Wisner November 15, 1999 7:31 PM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6 Sex 8. Date of Birth (Month, Day, Year) May 31, 1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 N F 69 Yrs. 205-22-2311 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Thomas Point Court 21234 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementary/Secondery (0-12) College (1-4or 5+) Owner Food Sales 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middla, Last) Mildred Peter Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mr. Kenneth D. Wisner (husband) 1 Thomas Point Ct., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 11/19/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimungh Funghal Home

Physician /Medical Examiner

Depertment of I

any Injury or

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

**Funeral** 

Director

Items 23a

Pages 1 end 2 should be filed within 72 hours after on nent of Health end Mentel Hygiena. Int: If Item 27 Ia marked other than "natural", or Item

WISUER STELLA

Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

State Registrar **DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) NOV 1 9 1999

23a. Part1. Enter the disaasa, or conshock, or heart failure. List only	nplications that caused tha dea y one ceuse on each line.			Baltimore, Mic or raspiratory errest.	D 21236 Approximate Interval Between Onset and Death				
Immediate Cause (Final disease or condition resulting in death)	a OVA	ViAN	CANCER		2 years				
	Dua to (	or as a consequence of)							
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying	Sequentially list conditions, fany, leading to immadiate cause. Enter Underlying cause. Enter Underlying c.								
that initiated events resulting in death) Last	Dua to (	or as a consequence of)							
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	cause given in Part t.	A A A A A A A A A A A A A A A A A A A	contribute to the cause of death?				
				1□ Yes 2□ No	3 Probably 4 Unknown				
				24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?				
				24a. Was en autopsy	24b. Were eutopsy findings available prior to completion of cause of death?				
25. Was case referred to medical			26. Place of De	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?				
25. Was case referred to medical axaminar? 1 ☐ Yas 2 ② No	Hospital: 1 Inpatiant 2	☐ ER/Outpatient 3☐ D	Othor	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?  1  Yes 2 No				
axaminar?  1 Yas 2 No  27. Manner of Deeth  1 Natural 5 Pending  2 Accident invastigation	28e. Date of Injury (Month, Day Year)		Othor	24a. Was en autopsy performed?  1 □ Yes ② No neth (Check only one)	24b. Were eutopsy findings available prior to completion of cause of death?  1 Yes 2 No				
axaminar? 1 □ Yas 2 ②No  27. Manner of Deeth 1 ③Natural 5 □ Pending	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	OA Other: 4 Nursing I 28c. Injury at Work? 1 Yes 2 No	24a. Was en autopsy performed?  1  Yes  No Note (Check only one)  Home 5 Residence 6 20  28d. Describe how injury occ	24b. Were eutopsy findings available prior to completion of cause of death?  1 Yes 2 No				
axaminar?  1	28e. Date of Injury (Month, Day Year)  28e. Place of Injury - At houlding, etc. (Special Special 28b. Time of Injury M  nome, farm, street, factor	OA Other: 4 Nursing I 28c. Injury at Work? 1 Yes 2 No  y, office	24a. Was en autopsy performed?  1  Yes  No No Neth (Check only one)  Home 5 Residence 6 20 28d. Describe how injury occurrence and Nur	24b. Were eutopsy findings available prior to completion of cause of death?  1  Yes 2 No  Other (Specify)					

**ORIGINAL** 

670/ M. Charles St. Balto. Md 21205

and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatura

CERTAIN AND H

### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

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State of Maryland / Department of Health and Mental Hygiene

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OTUMET	
WILSON	

Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** STANLEY Α. WILSON

2. Dete of Death 3. Time of Death NOVEMBER 16, 1999 7:04P.M.

/Medical Examiner

4a Facility Name (If not institution, give street and number) 3000 BLK W.GARRISON AVE

4b. City, Town, or Location of Death BALTIMORE

4c. County of Deeth

**Funeral** Director

5. Social Security Number XXM 2DF 216-92-7493

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Months Days Dec. 13 1978

Birthplece (Stete or Foreign Country)

ahow

"natural", or items 23s or 28s-f shoredical Examiner must be notified at

e filed within 72 hours effer all Hygiens.
Other than "natural", or its

permit. Peges 1 and 2 should be file.
Department of Health and Mental Hy,
Important: if item 27 is marked other
eny injury or other treumatic event,
pages.

Physician

/Medical

Examiner

physician and the burial-transit

i cartificata ha

the state of funeral

After

To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: After completely filled in by the fun

The lew requires that the death certificate be assected

Box 68760.

P.O.

Records.

of Vital Physician:

Division or Attending Examiner

Physician/Medical

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Completed

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Certification:

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

the Maryland

10a State 10b County MD NA

10c. City. Town or Location BALTIMORE

10d. Inside City Limits 1¥ Yes 2 No

MD

10e. Street and Number

10f. Zip Code

10g. Citizen of Whet Country?

3861 SHANNON DRIVE

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:

20

21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indien, Black, White, etc. Specify: BLACK

USA

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Harris

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

MOVER (FURNITURE)

LAUREL VAN LINES

17. Father's Name (First, Middle, Last)

WILSON

18. Mother's Neme (First, Middle, Maiden Surneme) LESLIE HUBBARD

STANLEY Α.

Elementary/Secondary (0-12)

12th

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

LESLIE HUBBARD - MOTHER

3861 SHANNON DRIVE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

BALTIMORE, MD 21213 20c. Location - City or Town, Stete Dete

20a. Method of Disposition

1 N Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

KING MEMORIAL PARK

112099 RANDALLSIOWN, MARYLAND

21. Signature of Funeral Service License

22. Name end Address of Fecility

MARCH FUNERAL HOME WEST, INC.

4300 WABASH AVE. BALTIMORE, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, about, or heart before. List only one cause on each line.

21215 Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

MULTIPLE GUNGAGE WOUNDS Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated enters.) that initieted events resulting in death) Last

Due to (or es e consequence of):

Due to (or es e consequence of):

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an eutopsy performed?

24b. Were eutopsy findings evailable prior to completion of cause of deeth?

1 Yes 2 No

1 Nes 2□ No

25. Was case referred to medical examiner? Yes 2□ No

27. Manner of Death

1 Netural

2 Accident

3 Suicide

40 Homicide

28a. Date of tnjury (Month, Day Year) 5 Pending investigation 11-16-99

6 Could not be determined

Hospital:

28b. Time of Injury 18:528

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

SMISTER WAS SHOT. 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele)

29a. Certifier (Check only

BOOGLEW. GISELLISON- DUE BOUTHOR CAR 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stelled.

29b. Signature and title of certifier

HARYARINA

29c. License number

29d. Date signed (Month, Day, Year)

all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KORFU MM.

O.C.M.E.

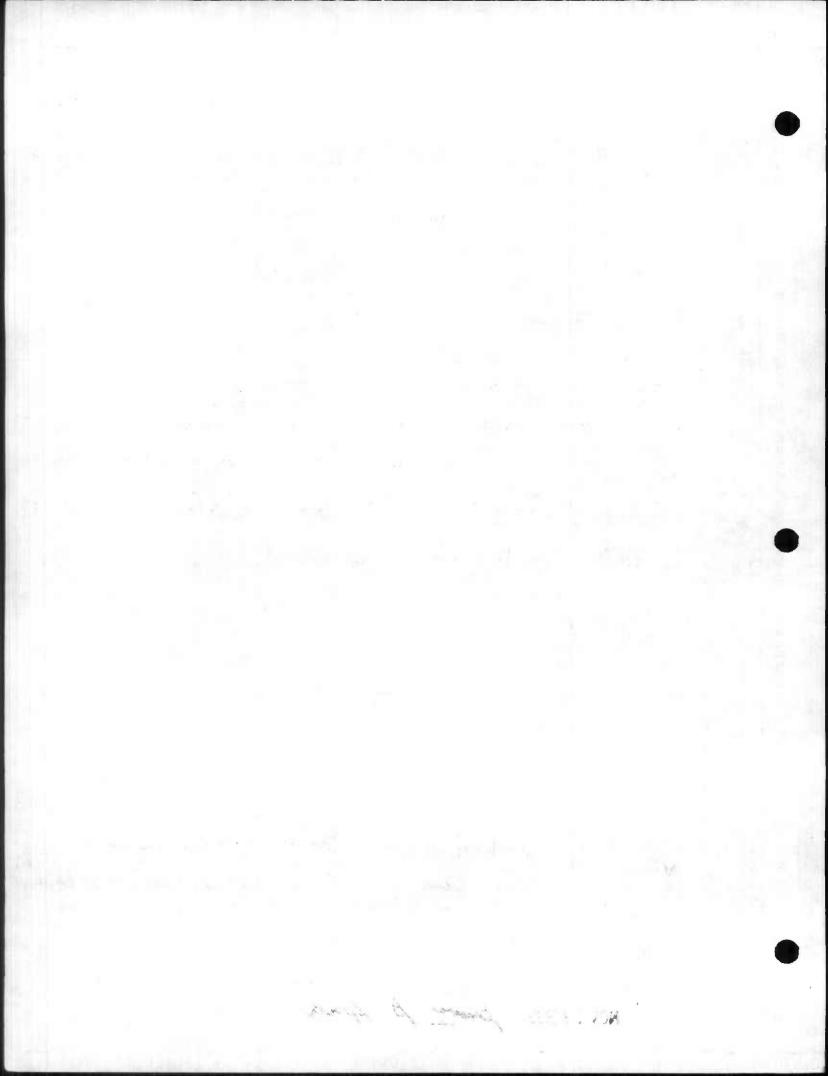
NOVEMBER 17, 1999

31. Date filed (Month, Day, Year) NOV 1 9 1999 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36279 AMEND ITEM 11#778 12-2-99 WR. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Deeth 2. Dete of Deeth Month **Physician** Charles William Yowell 1735 13 11 /Medical 4a Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deaton Medical Center Paltimore City Hours Min. 8. Date of Birth (Month, Day, Year)

May 1, 1922 5 Social Security Number It Undar 1 Yaar 9. Birthplaca (Stata or Foreign 7. Age (In yrs. last birthday) **Funeral X** M 2□ F Months Deys Yrs. Baltimore Maryland 217-14-1376 Director Usual Residence of Decadent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location notified a NA Yes 2 No Maryland Baltimore City Director 94 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 8 8 21230 601 North Charles Street United States Harrie 23a 12. Wes Decedent Ever in U.S. Armed Forces? MRYes 2□ No Marines I Yes, Giva Yaar or Detas: WIII 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lt Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian 11 Marital Status "natural", or Itam edical Examener Black, White, etc. 1 Never Married Specify: White 1 Yes 2 X Qo Specify: by 3 Widowed WDivorced ir than "naturi Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Security 8th Grade Security Guard 18 Mother's Name (First Middle Maiden Surname) 17. Fethar's Neme (First, Middla, Last) should be Mental marked Charles H. Yowell Lena V. Smith 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Ceraldine V. Yowell / Wife 600 Light Street, Baltimore Maryland 21230, Apt# 626 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, Stata 20a. Method of Disposition ъ Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Glen Haven Memorial Park, November 16, 1999 Paltimore Maryland 21. Signature of Funeral Service Licansee Victor P. 22. Neme end Address of Facility Charles L. Stevens Funeral Home, Inc. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximata intervel Between Onset end Deeth **Physician** Prevmonia /Medical Immediate Cause (Final disaese or condition resulting in death) Examiner Due to (or es e consequenca of) Examiner physicien end the burief-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 88 for use es signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? wellins 1 Yes 2 No 3 Probably 4 Unknown g The law requires 24b. Were eutopsy tindings availeble prior to completion of cause of death? should should 24a. Wes en eutopsy Completed performed? ate hes l 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate director, 25. Wes case reterred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) funerei 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? Certification: After Attending 1 Natural 2 ☐ Accident 5 Pendina 1 Yes 2 No investigation death. Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 | Homicide ŏ To the Hospital or within 24 hours aft To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the best of examination end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a, Certifier Medical 29d. Data signed (Month, Day, Yaar) 29b. Slo nature and title of certifier 29c. Licensa number MP D38675 30. Neme and add ress ot person who completed cause of deeth (Item 23e) (Type, Print) HANDYER ST BALTIMORE MD 21230 5 147 32. Registrat's Signature State Registrar

DHMH 16 Rev 6/95

Harles William yourel

MON 7 8 1838 Server

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Name (First, Middle, Lest)								Reg. No.  2. Date of Death  3. Time of Death				
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	Doctors Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 You					r 1 Voar	Lanham If Under 24 H			ice Geor			
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A notifie	10e. Street and N						p Code			10g. Citizen of	What Country?		
ral D	4606 Ho	1mehurst	Way		20720 USA								
by Funeral Director	11. Meritel Status  12. Wes Decedent Ever Armed Forces?  1 Never Merried 2 X Merried  1 Yes 2 No If Yes, Give Year or Detes:			Forces?	U,S.	13. Wes Dece		lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or North Rican, etc.)		ce - American lock, White, etc. by: Asian	ndian, Indian	
ted b	15. Decedent's Education 16a. Decedent's Usuel Occ. (Specify only highest grade completed) (Give kind of work done						uel Occup	pation	endrina	16b. Kind of B	usiness/Industr	ту	
he Medical Examiner in ampleted by Funer	(Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of wife. DO NOT use retired)						on any						
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any injury o	Fleck Funeral Home, Inc.												
	/ Whee	7601 Sandy Spring Road, Laurel, Maryland 20707											
	23a Part/ Enter	rithe disease, or o	complications the										
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State of Maryland / Department of Health and Mental Hygiene 99 36281

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Exami		4a Facility Nama (If not institution, go	iva street and number)					ocation of Death	4c. County		
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Funera Director		215-34-5159	Sex 7. Ag 1 M 2 F	ga (In yrs. last bii			Indar 24 Hrs. ours Min.	8. Data of Birth (Month, Day,		Countr	aca (Stata or Foraign ry) Sylvania
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dev Rosa 12:18 **Physician** Marie NO Vember 7 Breazil /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Deten Hospital If Under 24 Hrs. Hours Min. If Under 1 Year Birthpieca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 S Months Devs Yrs. Director July 28,64 New York 054-60-2262 Usuel Residence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits th end Mental Hygiene.
The marked other than "naturel", or Nama 23a or 28a-f ehov traumatic event, the Madical Executer must be notified. 1 Yes 2 □ No Director Maryland Charles Hughesville 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? Funerai 12831 Grosstown Road 20637 U.S.A. 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decadent Ever in U,S. Armed Forces? Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours aftar one of Health end Mental Hygiene. 1 Yes 25 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes ≱☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Breazi Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Roosevelt Cauthen 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health of Itam 27 is Mary Cauthen/ Mother 12831 Grosstown Road, Hughesville MD 20637 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donaţion 5 ☐ Other (Specify) Department of Important: If it any injury or o 11/12/99 Bryantown Maryland St.Marys Ch 22. Name end Address of Fecility ADAMS FUNERAL HOME P.A.AQUASCO MD M00191 20608 23a. Part1. Error the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner mycobacterium avium intrucellulare Examiner physician end the burial-transit tha death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): - allvancec Box 68760. Physician/Medical Due to (or es e consequence of): USe signed by the a d be detached f Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contribute to the cause of deeth? Ö 1 Yes 2 No 3 Probably 4 Unknown tuxoplasmosis, analmia of chranic Division of Vitai Records, by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy disease, HSV-II 1 □ Yes 2 □ No 1 Yes 2 No i or Attending Physician: after deeth. Director; After this certifica Be 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To funeral 28c. Injury et Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Naturel 5 Pending NA 1 1 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗓 🍪 tifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. Medicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner stated. 29b. Signature and title of personal 29c. License number 29d. Dete signed (Month, Dey, Year)

Bulpmere MD

Registrar

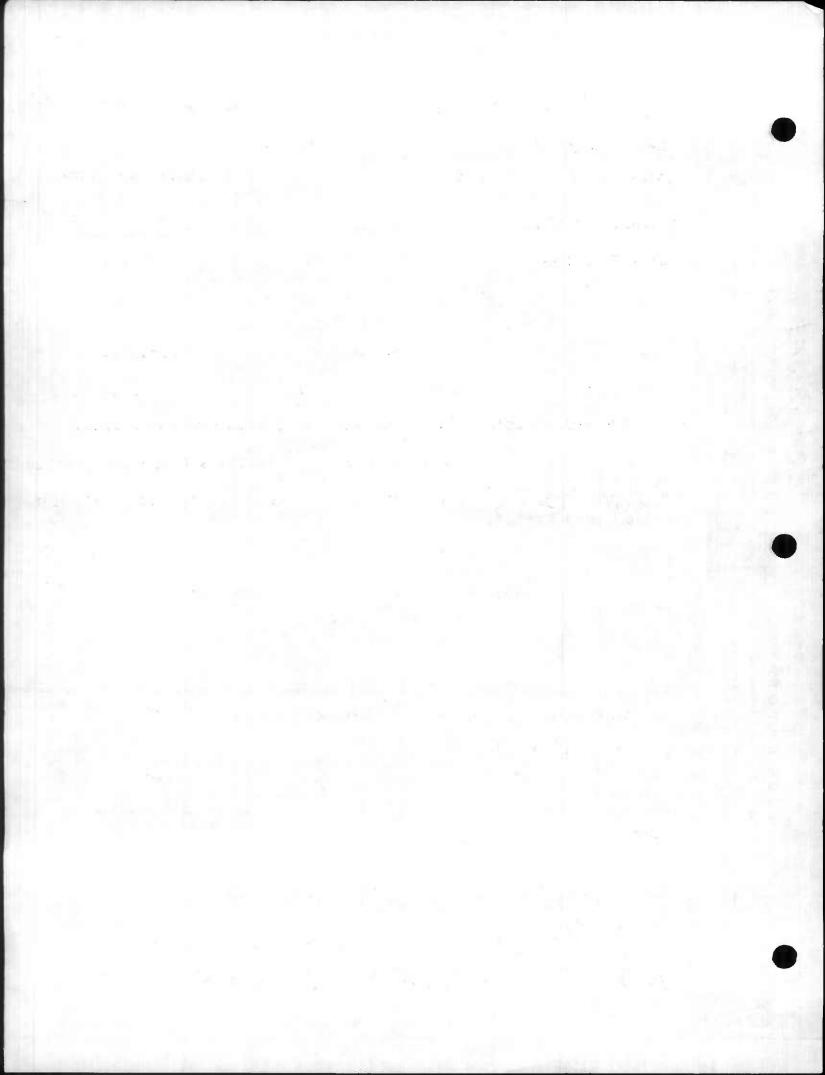
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. Charles

32. Registrer's Signature Tenewa

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31. Dete filed (Month, Dey, Year) NOV 1 0 1999

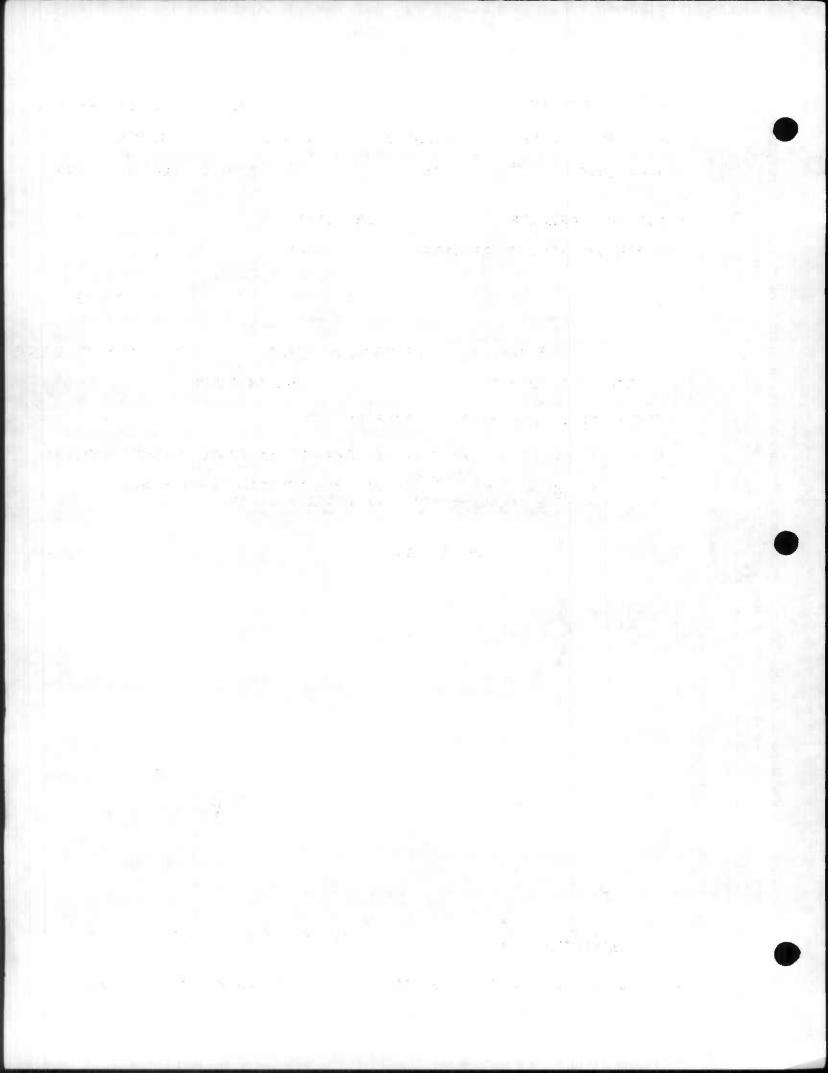


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 3 6 2 8 3

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** CECILIA BENNETT NOVEMBER 9,1999 4:54AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 300 HARFORD STREET-APARTMENT 3D CHARLES LA PLATA 7. Age (In yrs. last birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Devs | Hours | Min. | (Month, Dey, Year) 5. Social Security Number Birthplece (Stete or Foraign Country) 6. Sex **Funeral** 1 MX2 F Yrs. SEPT.19,1905 NEW 578-42-9375 94 Director YORK Usual Residence of Decedent the Meryland Peges 1 and 2 should be filed within 72 hours efter deeth with the Menylen nent of Health end Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show many or other than the Medical Estating matter notified any or other traumatic event, the Medical Estating matter notified a 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director LA PLATA MARYLAND CHARLES 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 300 HARFORD STREET APT.#3-D 20646 U.S.A, Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 12. Was Dacedent Ever in U.S. Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes O☐ No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE à 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) RESTAURANT OWNER SELF EMPLOYED FOODS yrs. 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Surnema) Be LEOPOLD LUPOVITCH SADIE GOTCH 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) SYLVIA POOLE DAUGHTER SAME AS #10 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Sp Buriel 2 ☐ Cremetion 3 ☐ Ramoval from State permit. Pege Department of Important: If any Injury or once. TRINITY MEM.GARDENS 11-12-99 WALDORF, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Pert1. Enterthe disease, or complications the Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical LUNG CANCER 6 months Examiner Due to (or es e consequence of): Examiner physicien end s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 an/Medical Due to (or es e consequence of): ettending ph Physici signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings aveilable prior to 24a. Was en autopsy performed? Completed completion of cause of deeth? s certificate has b director, page 2 s 200 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? director Be 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home SA Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation Naturel 1 Yes 2 No death. 2 Accident efter deatl 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) • Funeral Dire Hospital 29a. Certifier edicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medicel Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signatura and titla of certified 29c. Licensa number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 6620 CRAIN HWY. SUITE 101 LA PLATA, MD. 20646 A.H.FADUL, M.D. 32. Registrar's Signature 1 0 1999 State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 36284 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea 1:00pm Julia Baisley November 1 1999 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Daath 4c. County of Death 3702 Lochearn Drive Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 19 1914 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days 1 □ M 2 👿 F 220-24-2120 Yrs. Pa. Usual Rasidence of Decedent 10b. County 10c. City, Town or Locetion 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 X No 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 3702 Lochearn Dr 21207 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yas 2 No If Yes, Give Year or Dates: 1 □ Navar Married 2 □ Married Specify: White 1 Yes 2 No Spacify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) store manager retail sales 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Krolick Eva Boris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Patricia Garrison (daughter) 3702 Lochearn Dr. Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from Stata Lake View Memorial 11-6-99 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funarai Sarvice Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Vaige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath Endliss of noticeross Immediate Cause (Final disaase or condition resulting in daath) Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner

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To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by

The law requires that the deeth certificate be executed

P.O. Box 68760

Division of Vital Records,

or Attending Physician:

**Physician** 

/Medical

**Examiner** 

10a. State

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Director

Funeral

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Completed

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Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at each.

altimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated events rasulting in daath) Last

Dua to (or as a consaquenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed?

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Hospitai:

1 TYAS OFTEN 1 □ Yes 2 □ No

25. Was case ratarrad to medical axaminar? 1 Yes 2 No 27. Mannar of Daath

26. Place of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Natural 5 Pending

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No

2 Accident 3 ☐ Suicide 4 ☐ Homicida

investigation 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

MORDER SOOM

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🕒 Certifying Phyelclan: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. Licansa number

29th Date signed (Month, Day, Year)

30 Name and address of person who complated cause of daath (Itam 23a) (Type, Print)

, M.D 31. Date filed (Month, Day, Year)

Rd. Str. 300 PIKESVILL, MD 2120

Registrar

32. Registrar's Signature NOV 0 4 1999

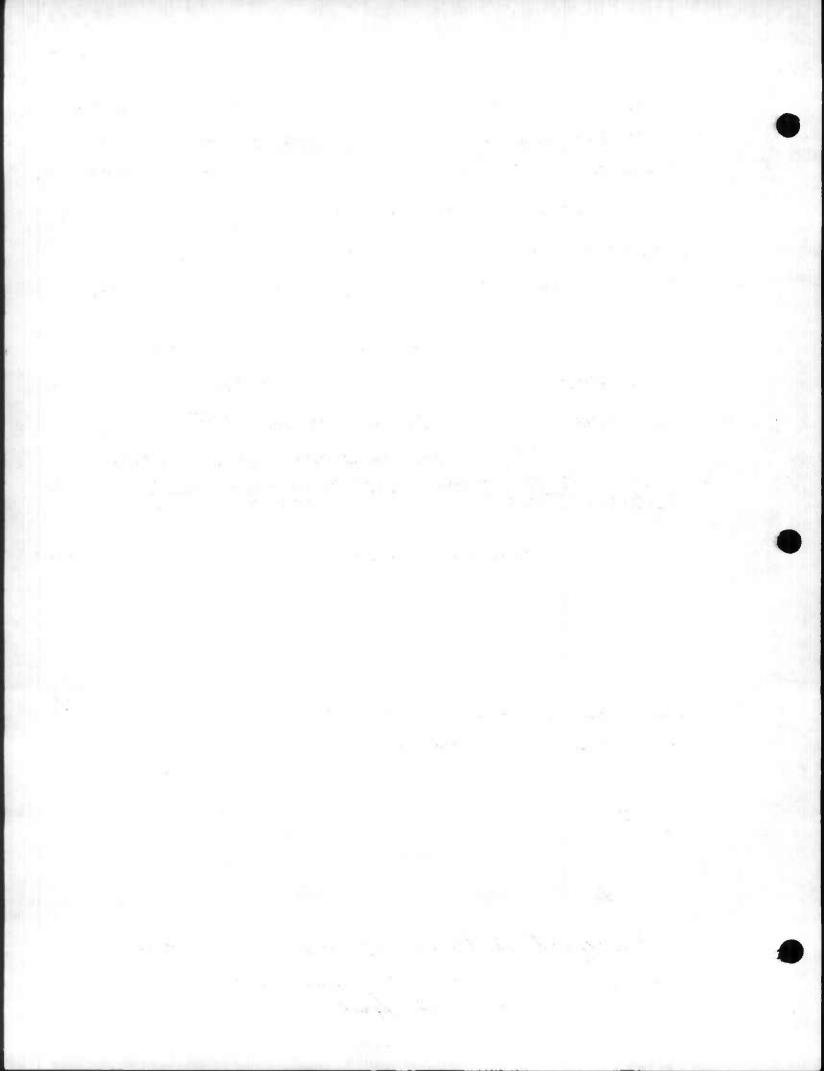
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36285 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RUTH MARIE BOWSER Nov. 1999 8:45 AM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 572 ASHER GLADE ROAD FRIENDSVILLE MD GARRETT CO If Under 1 Year 8. Date of Birth (Month, Dev. Y 9-11-19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Hours Months Days 1 M 2 F Yrs. 80 172-16-7570 **Director** COOLSPRING PA. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location natural, or Items 23a or 28a-f show of call Examiner must be notified at 10d. Inside City Limits GARRETT CO. FRIENDSVILLE MD 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 572 ASHER GLADE ROAD 21531 USA death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Year or Dates: Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be 1 Department of Haaith and Mental Important: If Item 27 Is marked or any Injury or other traumatic eve EDGAR DEVAULT LYDA SHOAF 0 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) FRIENDSVILLE, MD 21531 RALPH BOWSER 572 ASHER GLADE ROAD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ASHER GLADE CEMETERY 11-4-99 FRIENDSVILLE MD 22. Name and Address of Facility
SOWERS FUNERAL HOME 60 W MAIN ST
FROSTBURG, MD 21532 21. Signature of Funeral Service m-00900 £ Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final a Congestive heart failure 10 years disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): and Box 68760, Physiclan/Medical the Due to (or as e consequence of) 88 use atten ō Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 SUnknown Poorly controlled diabetes type II, Megacolon, signed t þ Records. Be Completed 24b. Were autopsy findings evelleble prior to 24a. Was an autopsy performed? should chronic GI bleed, anemia, chronic renal failure completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital Hospital or Attending Physician:
 24 hours aftar death.
 Funeral Director: After this cartifical lately filled in by the funaral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 25 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Injun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complately filled in Certifying Phyeiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 5 11/1/99 D26650 30. Name end eddress a purson who completed cause of death (Item 23e) (Type, Print) nus PO Box 486 M.D. Oakland, MD 21550 A. Kaiser, Margaret 32. Registrar's Signature State Registrar



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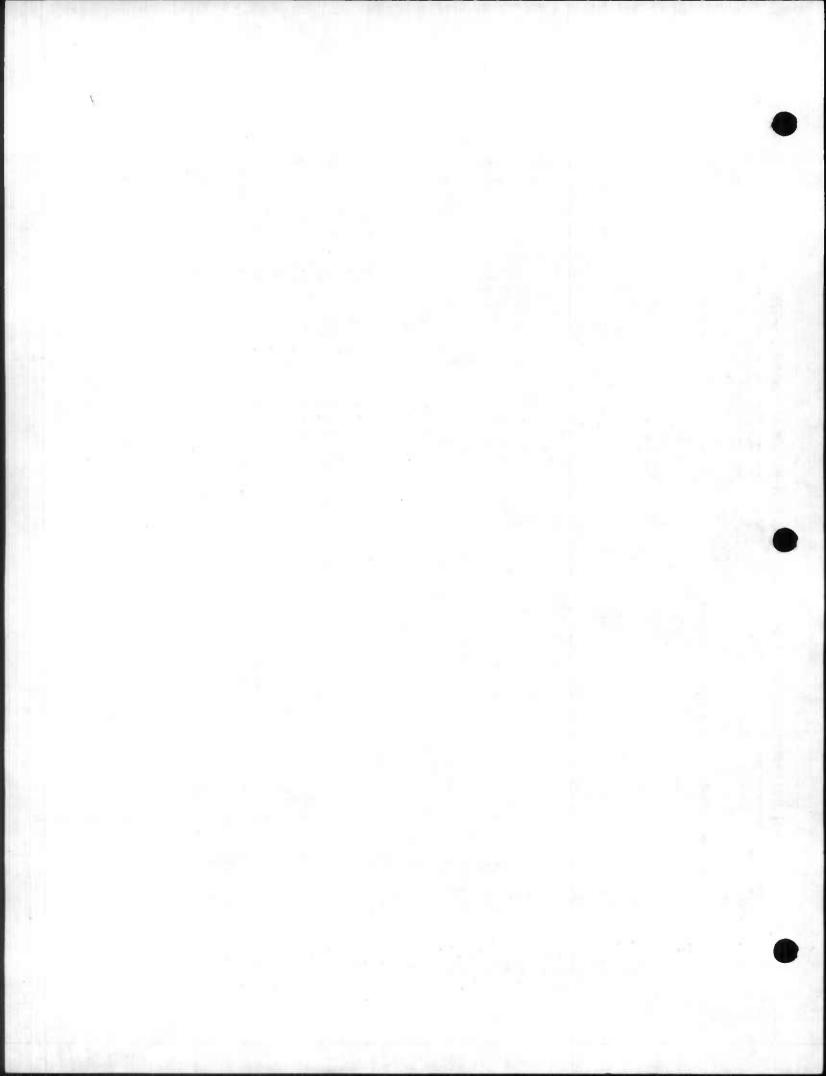
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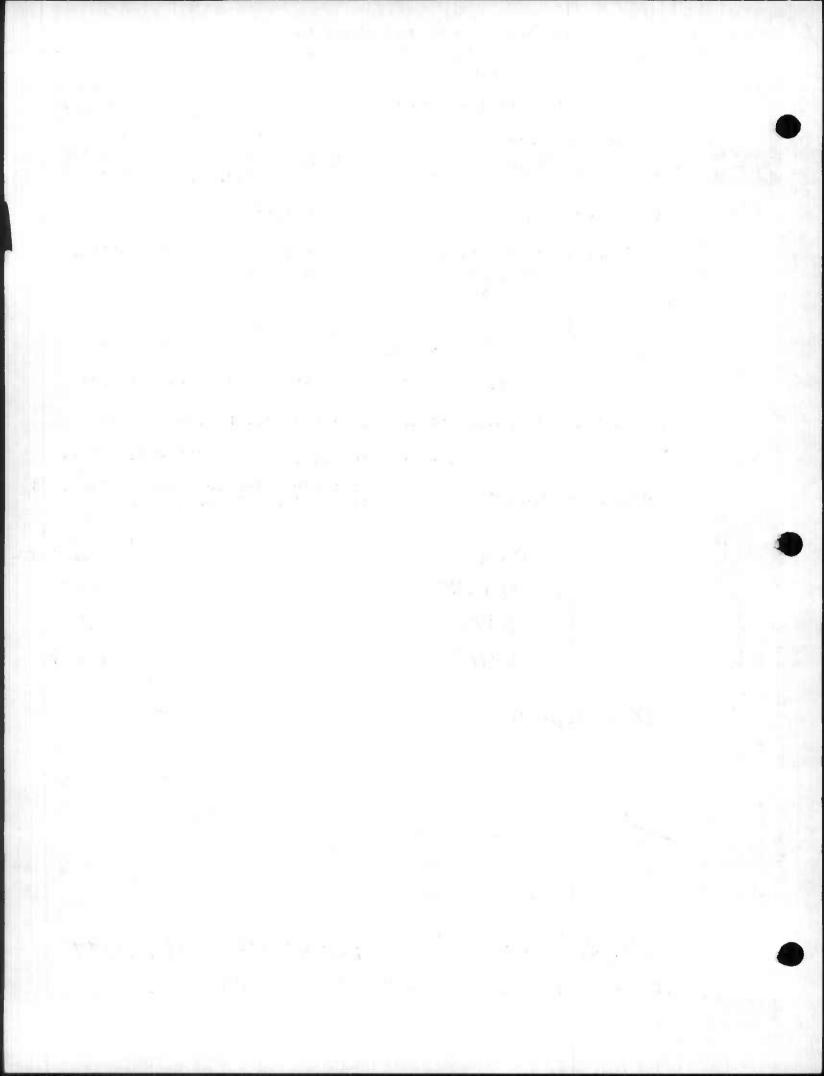
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25 Ed		19e. fnforment's Neme/Reletionship (Ty Donna F. Boyden	/Wife	6791	Whitel	y Road	, Hurlo		21643		
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Baltim permit. Par Department Important:	buce	21. Signeture of Funeral Service Licens  Michael 7.	Eskow	Fr	Name end Address amptom derals	-Hawki burg, M	ns-Esk	ow Fune 632	ral Home		
Physicia /Medic Examine	al	23a. Pert1. Enter the disease, or complishock, or heart feilure. List only or immediate Cause (Final disease or condition resulting in deeth)	ASONO Oberolor COTONO	es e conseque	onem jendo ot): tery d	isease			Interval Between Onset and Death		
requires that the death cardificate be executed requires that the death cardificate be executed reen signed by the attending physician and hould be detached for use as the burial-transit	Medical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	o	es e consequ							
ds, P.O. B uiras that the deat signed by the att	by Physician/	Pert II. Other significant conditions cor	tributing to death but not result	ting in the un	derlying cause gi				co use contribute to the cause of death?  25 To 3 Probably 4 Unknown		
2 8 8	Completed b							s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?		
The land	Соп						10	Yes 2 No	1□ Yes 22(No		
of Vital I Physician: The this certificate	Be	25. Wes case referred to medical examiner?	lospitel:		_   Ot	hor	eeth (Check only				
Physic ruthis of prai direction	T: To	1 ☐ Yes 2 No  27. Menner of Death	28a. Dete of friury	R/Outpatient 28b. Time of	3□ DOA   28c. Inju	4   Nursing		how injury occurr			
Division of all or Attending Pater death.  I Director: After the in by the funers	Certification:	1 Neturel 2 Accident 3 Suicide 4 Homicide  5 Pending Investigation Could not be determined	(Month, Dey Year)  28e. Pleca of Injury - At hon building, etc. (Specify)	Injury ne, farm, stre	M 1	rk?  Yes 2∐No		(Street and Numbown, State)	er or Rural Route Number,		
Divi	edical Cer	(Check only 2 Medical Examin	sician: To the best of my know	fedge, deeth	occurred et the ti	me, date end place	ce, and due to the	e cause(s) and ma	nner as stated. and due to the cause(s)		
To the I within 2 To the complet	Med	29b. Signeture and title of certifier	and menner stated.		29c. Licens			29d. Date signed	(Month, Day, Year)		
		· Mannon	resident ph	15ician	191	2400		11/0	3/199		
		30. Name and address of person who co	empleted cause of death (Item s	23a) (Type, P	(rint)	Marylan	A				
Regi	State strar	31. Dete filed (Month, Day, Year) NOV = 5 1999	32 Registrer's Signetu	par	EN						



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 35288

					Ce	ertificate of	Death		Reg. No.	30200
	Physic	ion	Decedent's Neme (First, Middle, Last)					2. Date of De Month		3. Time of Death
J	/Medi			EN MARIE	BUL			NOV.	9, 1999	1630
9	Exami	ner	4a. Facility Name (If not institution, give street ar			1.0	4b. City, Town, or Lo		4c. County of C	
ŀ			2768 Choptank Mai  5. Social Security Number 6. Sax	7. Age (In yrs. la	et hirthda	/) If Under 1 Yaar				
	Funerai Director		220-03-6050 1 M 34			Months Days	Hours Min.	8. Dale of Bir (Month, Da Mar. 18	y, Year) , 1919	Birthplaca (Stata or Foreign Country) Maryland
	he Merylen (8a-f show		10a. Slata 10b. County	10c. City	Town or I	Location	Dunatan			10d. Inside City Limits
		cto	MD Caroline				Preston			1 □ Yas 2 No
	th with th	Funeral Director	10e. Street and Number 2768 Choptank Mai	n Street		10f. Zip Code	21655		10g. Citizen of Wha United	
21215-0020	within 72 hours effer deeth with the Meryland ene, than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 if Ye	Decedent Ever in U,S ed Forcas? Yes 2 X No s, Give or Dates:	. 13	13. Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:		ecify Yes or No Rican, etc.)	14. Race - A Black, V Specify:	American Indian, White, etc. White
5-0	"neturel",	Completed	15. Decedent's Education (Specify only highest grade comple	ated)	16a. Dec	edent's Usual Occup e kind of work dona	pation during most of worki	na	16b. Kind of Busine	ess/Industry
121	within ane. then	mpl		nge (1-4or 5+)		Stress	during most of worki		Sports	wear
Maryland 2	s 1 end 2 should be filled within Health end Mental Hygiene. tem 27 is merked other than " other traumatic event, I're Me	Be	17. Father's Nama (First, Middle, Last)	and Cham		301033	18. Mother's Neme	(First, Middle,	Malden Surname) Ders Cha	mbers
ary	shoul nd Me mark	J.	19a. Informant's Name/Relationship (Type, Print	)	19b. Mai	ling Address (Street	and Number or Rura	l Route Numb	er. City or Town. Sta	te. Zin Code)
-	1 end 2 Health e		Barbara Quathamer							
Baltimore,	ege ent o ft: If i		20a. Method of Disposition  1 ⋈ Burial 2 □ Cremation 3 □ Ramovai 4 □ Donation 5 □ Other (Specify)	rom State	metery, cri	oosition (Name of ematory or other place or der		Date 1/12	oreston,	or Town, Stata Maryland
Balt	permit. Per Department Important: any Injury once.		21. Signature of Funeral Servica Licensea  Wuhusi 7. Gab	w	F	ramptom	ess of Facility - Hawkins 3, Feder	-Eskov	Funera	1 Home, PA
			23a. Part1. Enter the disease, or complications shock, or heert failure. List only one cause	hat caused the death.	Do not er	nter tha moda of dyir	ng, such as cardiac o	r raspiralory a	resl,	Approximata Interval Between
	Physician /Medicai Examiner	Je.	Immediata Cause (Final disease or condition resulting in death)	AD  Due to (or		equence of):				Onset and Death
0,	icate be executed physician end s the buriel-transit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	N 10 DM Due Io (or	as a conse	equence of):				400
x 68760,	law requires that the deeth certificate be executed es been signed by the ettending physician end a should be deteched for use as the buniel-transit	/Medical	Cause (Disease or Injury Ihal initiated events resulting in death) Last				Hunter			
Box	eeth etter	Physician/						1		
0	t the de by the teched	hysi	Part II. Other significant conditions contributing	To death but not result	ting in the	underlying cause giv	ren In Part I.			oute to the cause of death?  ☐ Probably 4 ☐ Unknown
ر. ص	es thet igned be det	by P	pancytopen	~				'	TOS ZIMPRO SI	J Probably 4 Dinkhown
of Vital Records,	aw require as been sig 2 should b	Completed b							an autopsy rmed?	4b. Were autopsy findings available prior to completion of cause of death?
Ä	0 - 0	E						10	res 2 No	1 ☐ Yes 2 ☐ NO
/ita	iclan: Th	Be	25. Wes case referred to medical examiner?				26. Place of Deeth	(Check only o	ne)	
) t	P 40 T	ို	1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ E	R/Outpatie		4 LI Nursing Hor		dence 6 □Other (5	Specify)
	Ing P	inol in	1 ☑Natural 5 ☐ Pending	Date of Injury Month, Day Year)	28b. Time Injury	Wor		28d. Describe I	now injury occurred	
Division	ii or Attending Phy is efter deeth. I Director: After this d in by the funeral of	Certification:		Place of Injury - At hon ouilding, etc. (Specify)			Yes 2 □ No	28f. Location (S City or Tox		r Rural Routa Number,
	Hospita 14 hours Funera tely fille	edical Ce	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	he basis of examination	ledge, dea	th occurred et the tir	ne, date and placa, a	and dua to the	cause(s) and manne date and place, and	r as stated. due to lhe cause(s)
	To the within 2 To the comple	Med	29b. Signatura and little of certifier	manner stated.		29c. Licens	a number		29d. Dale signed (M	fonth Day Year)
	F 3 F 8		Alakal Zathry	del esbech		_			11/1	1/90
			30. Name and address of person who completed	cause of death (Item !	23e) (Type		05311		11/1	1/1/
			(007 1)11+CH	mans	Le	ane E	aston	MD	21601	
	Sta	ite	31. Date filed (Month, Day, Year) NOV 1 2 1999	. Registrar's Signatu	re/g	loo 1	,			
	Regist	ar	// NOV 1 2 1999	/	· .	popular	y			



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Q 36289 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Data of Death 250AM **Physician** NOUEMBER John Albert Bruce BIESEL /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stella Maris at Mercy Hospice Baltimore If Under 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthdey) 6 SAY Birthpleca (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Hours 1 M 2 □ F Yrs. 214 30 0831 64 Director Jan. 28, 1935 IL Usuel Residenca of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be politied at Anne Arundel Crofton 1 ☐ Yes 2X No Director MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1573 Fallowfield Court 21114 death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar In U,S. Armed Forcas? Raca - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or ite any Injury or other treumatic event, the Medical Examine any logical. 1 M Yes 2 No If Yas, Giva Yeer or Detes: 1952-53 1 Never Merried 2X Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast greda complated) Elementery/Secondery (0-12) College (1-4or 5+) retail food distrib-10 electrical engineer tion 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Aileen Louise Jaquith William Trimble Biesel 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) same as 10 above Rose Anne Biesel (wife) 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Burial 2 ICramation 3 ☐ Ramoval from Stata 11-6-99 Alexandria, VA Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Rausch Funeral Home, Owings, MD Approximata Intervel Between Onset and Death 23a. Part1. Entar the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. **Physician** /Medical Immediata Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physiclen and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Dua to (or es e consequence of): Pert fl. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sulmonary disease 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of causa of daeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Wes case referred to medical examinar? 26. Place of Deeth (Check only one STE ! A MARIS AT MERC Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOS PICE Hospital: 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier LECTIFYING Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end placa, and due to the cause(s) end menner steted. edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier U 8 30. Name and address of person, who complated cause of deeth (Item 23a) (Type, Print) BALTIMORE MD 21202 DERG 31 Dete filed (Month, Day, Year) 32. Registrans Signature State NOV 08

**DHMH 16 Rev 6/95** 

Registrar

1999

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	State of Maryland / Department of Health a  Certificate of Death	Reg. No.
Physician /Medical	1. Decedent's Nama (First, Middle, Last)  RICHARD E • CLARK	2. Data of Death Month Day Yaar NOV 2 1999 10:15 pm
Examiner Funeral Director		With, or Location of Death  L Air Harford  24 Hrs. 8. Date of Birth (Month, Day, Year)  June 3,1932 Dublin, MD
show of all	Usual Residence of Dacedent  10a. State 10b. County 10c. City, Town or Location	10d. Insida City Limits
the Maryle 28a-f shon notthed at	Maryland Harford Bel Air	1 ☐ Yes 2 🕱 No
with the part of 28 band	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
led within 72 hours effer deeth with the Maryland Ngiene.  Ngiene.  At the Medical Examiner must be notified.  Completed by Funeral Director	2509 Conowingo Road  11. Marital Status  1 Never Married 2 Married 3 Widowad 4 Divorced  2509 Conowingo Road  12. Was Dacedant Ever in U.S. Armed Forces?  12. Was Dacedant Ever in U.S. Armed Forces?  13. Was Decedant of Hispanic Original It Yas, specify Cuban, Mexicen It Yes, Giva Yaar or Dates: 53–55	
d within 72 hours of giene. In Medical Exam.	15. Decedent's Education (Specify only highest grada completad)  Elamantary/Sacondary (0-12)  1 2  16a. Decedent's Usual Occupation (Give kind of work dona during most life. DO NOT use retired)  Owner	t of working  16b. Kind of Business/Industry  Hardware Store
d 2 should be filed th and Mantel Hygis 7 is marked other traumatic event, II	17. Father's Name (First, Middle, Last)	ars Name (First, Middle, Malden Sumama) atherine Halsey
2 sho end t	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Number, City or Town, State, Zip Code)
or Heal	Anne R. Clark - Wife 2509 Conowingo  20a. Method of Disposition  1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cematery, cramatory or other place)  Darlington Cemeter	Road, Bel Air, MD 21015  Date 20c. Location - City or Town, State  Darlington, MD
Baltimo permit. Pege Department of Important: If any Injury or any Injury or	21. Sign turn of Funeral Service Licensaa 22. Name and Address of Facility	
Color of the buriel-transit estimate Examiner eelical Examiner		na lyeur
ret the death certificate to by the attending physician/Medic	d.	i 23b. Did tobacco usa contribute to the cause of death
Phys the Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part i.	1 Yee 20 No 3 Probably 4 Unknow
aw requir s been s 2 should		24a. Was an autopsy performed?  24b. Ware autopsy findings available prior to completion of cause of daath?
= = # 0		1 Yes 2 No 1 Yas 2 No
	examiner? Hospital:	e ot Death (Check only one)  ursing Home 5 🕱 Residance 6 □Other (Specify)
ding After fune	27. Mannar of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	No  28t. Location (Street and Number or Rural Route Number,
To the Hospital or Attention within 24 hours effect deat to the Funeral Director: completely filled in by the Medical Certifical	28e. Place of injury - At home, tarm, street, tactory, office building, etc. (Specify)  29a. Certifier  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date an	City or Town, State)
he Hospi in 24 hou he Funer pletaly fil	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, data and manner stated.	
To the vithing To the comp	29b. Signature and title of certifier  29c. License number  D 3 Y U J Z	29d. Date signed (Month, Day, Year)  11/3/99
/6	30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)  Scott S. Haswell, MD, 2 North Avenue, Bel	
State Registrar	31. Date filed (Month, Day, Year)  NOV 0 4 1999  32. Registrar's Signature  4. South	

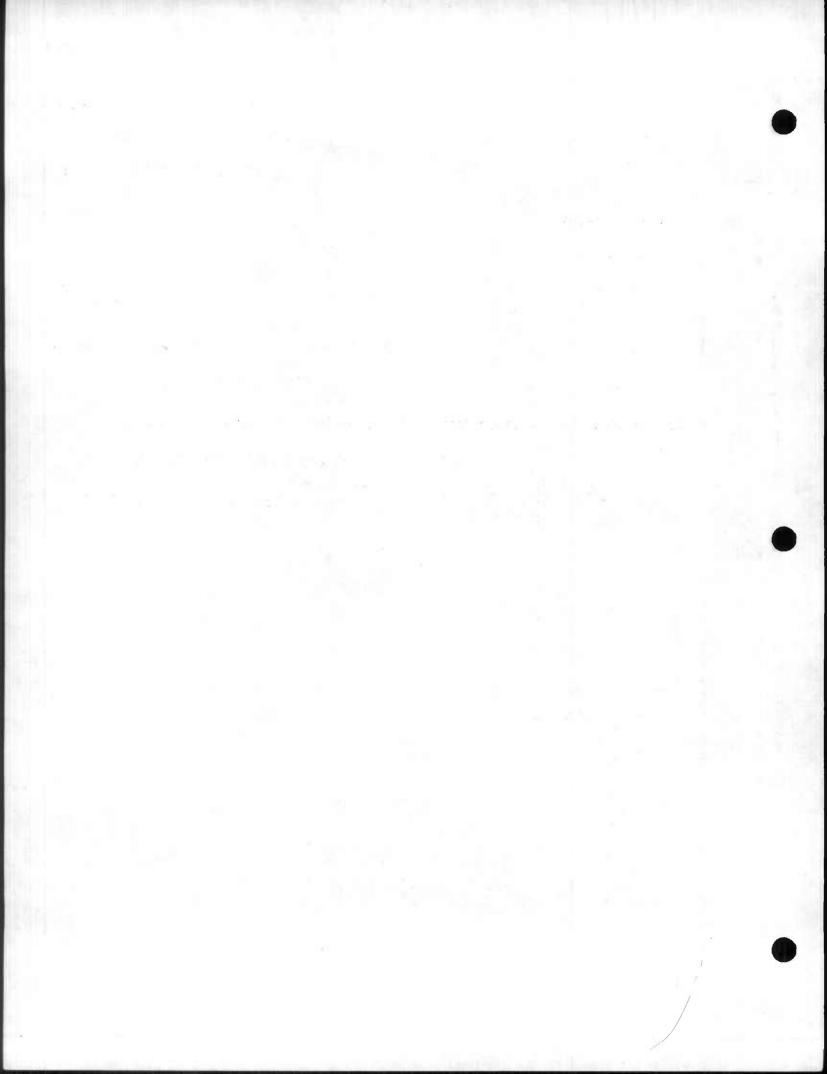
DHMH 16 Rev 6/95

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#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36291

			C	ertificate	e of	Death		Re	g. No.		OLDI
	1. Decedant's Nama (First, Middle, La	st)		5111				Data of Death	)	Maria	3. Time of Death
Physician /Medical	Ruth Viviar	n Coll	ins					<sub>Month</sub> vember	Day 3 19	99	4:50 AM
Examiner	4e Facility Neme (If not institution, giv	e street and number	)			4b. City, Town	n, or Location	on of Death	4c. County	of Deeth	
	Mariner Health	of Forest	Hill			Fore	est Hi	11	Har	ford	
Funeral	5. Sociel Security Number 6. S		ge (In yrs. last birtho	Months	1 Year Days	If Under 24	4 Hrs. 8. I	Date of Birth Month, Day,	Year)	9. Birthp	plece (Stete or Fore
Director	219-18-5257	□M 2 1 F	74 Yrs	B. MOTALIS	Days	riouis		v. 17	, 1924	Penn	sylvania
	Usual Residence of Decedent										
al, or items 23s or 28s-f show Examiner must be notified at by Funeral Director	10a. Stete 10b. County		10c. City, Town o	r Location						1	Od. Inside City Lim
cto Eff	Maryland Harford		Stree	t							1□Yes 2□
or 2	10e. Sfreet and Number			10f. Zip	Code			10	g. Citizen of \	What Cour	nfry?
a is	3038 Conowingo Ro	ad			211	54			USA		
rion must be notified Funeral Director	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Wes Deced	lent of h	lispanic Origi	in? (Specify	Yes or No-		e - Americ	an Indien,
를로	1 Never Merried 2 Married	1 ☐ Yas 2 🔀		1 Yes 2			1 0010100	11, 010.)		- 1000	
by	3 Widowed 4 □ Divorced	Yaar or Datas:		10 165 2	20110	Specify.			Specify	Wh	ite
pet	15. Decedent's Ed (Specify only highest gra	ducation	16a. De	ecedent's Usua	l Occup	pation	of working	1	6b. Kind of B	usiness/In	dustry
Completed	Elementary/Secondery (0-12)	College (1-4or	5+)	ive kind of wor le. DO NOT us							
000	8		Asse	mbly Li	ne '	Worker		R	ubber 1	Manuf	acturer
Be	17. Fether's Neme (First, Middle, Last)								la <i>iden Sum</i> en	10)	
70	David Woodley	Thompson				Oliv	re Mai	rie R	ouse		
	19e. Informent's Neme/Reletionship (	Type, Print)	19b. M	leiling Address	(Street	end Number	or Rural Ro	ute Number,	City or Town,	State, Zip	Code)
	Patricia White/ Da	ughter-In	-Taw 3	038 Con	iwor	ngo Rd	. St	reet.	MD 211	54	
5	20e. Method of Disposition		20b. Place of D		ne of		-		Oc. Location -		own, Stata
once.  To Be Completed	1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific			Memori			0 111	6-00 P	ol Nir	Max	bre ly
	21. Signature Funeral Service Ligar		Bel Air	22. Name and				0-99   D	ET ATT	, Mau	yrana
ouce.	1/40-1/4 /	Ene 1		McComas				P.A.			
	yaves of	myes.		50 W. E	Broa	dway S	street	, Bel	Air, M	D 210	
8.	23a. Pert1. Entar tha disease, or com shock, or heert failure. List only	plications met ause on came en eech l	d the death. Do not ine.	enter the mode	e of dyir	ng, such es ca	ardiac or res	spiratory arre	sf,	1	Approximata Intervel Between
ian										1	Onset and Death
eal ner	Immediate Cause (Final disease or condition		deland	luti	-					i	< Tim
Vie	resulting in death)		Due to (or as a con	sequence of):							
i e		b	pass	nuite	the	_				i	< Tm
Examiner	Sequentielly list conditions,	0.	Due to (or es a cor	sequence of):							
	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury									1	
edical	that initieted events resulting in death) Lest	C.	Due to (or es a con	sequence of):						1	
Medical Examir										-	
20		d								1	
Physician/	Pert II. Other significant conditions of	ontributing to death I	out not resulting in th	e underlying ca	ause giv	ven in Pert I.		23b. Dld tol	bacco use co	ntribute to	o the cause of dea
by Physician		00	1				45	1 🗆 Ye	8 2 No	3 Pro	bably 4 Unkn
y E	house den	lukus	ween				_				
	+ 1.							24a. Wes en		24b. W	are eutopsy finding eilable prior to
Completed	seg we						_	periorn	iour	Ç0	mpletion of cause deeth?
E	9							1 🗆 Ye	s 20 No	11	Yes 2 No
	25. Was case referred to medical					Of Diago	of Dooth (C)	neck only one			3.00 250
o Be	examiner?	Hospital:	• • • • • • • • • • • • • • • • • • •	all 00	Ott	ner 1					L.1
	27. Menner of Deeth	1 ☐ Inpati				_	1		nce 6 Oth w injury occur		γ)
Certification:	Natural 5 Pending	(Month, De	ay Year) Inju	ry M	Bc. Injus	rk? Yes 2□N			,,		
Ca	3 Suicide 6 Could not be		jury - At home, farm			700 20.		Location (Str	peet and Numl	her or Run	al Route Number,
Ī	4 Homicide determined		tc. (Specify)	, street, lactory	, onice			City or Town,		JOI OF THUIS	arriodic rediliber,
Ö											
edical	(Check only 2 Medical Exam	<b>ysician:</b> To the best niner: On the basis o	of examination and/o								
	one)	and mannar st	lated.								
Σ	29b. Signatura end title of certifier					se number		29	d. Data signe	d (Month,	Dey, Year)
	Haw 3.	1)Cu	~	0	3 -	2255					
	30. Name and address of person who	completed cause of	death (Item 23a) (Ty			- 1					
	To Stilled		15 w. (		4.	/					
State	31. Dete filed (Month, Dey, Year)		rar's Signature			-					
State	= 4000	here	a le		1	7					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death CAMPBELL DANIEL ROBERT 99 0330 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death OCEAN DOWNS BERLIN WORCESTER 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1 XM 2□ F Months Deys Hours Min Yrs. 108-38-8330 2-17-47 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. WORCESTER BERLIN 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? RACETRACK RD. 21811 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) EQUIP. OPERATOR CONSTRUCTION 18. Mother's Neme (First, Middle, Maldan Surnama) 17. Fether's Neme (First, Middle, Last) JOHN Boyn CAMPBELL RUTH PATHE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) RACETRACK RD. CAMPBELL BERLIN, MD. LORRAINE 21811 20b. Place of Disposition (Name of cametary, cramatory or other placa)
SALISBURY CREMATORY 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 11 - 9SALISBURY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lis 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 in 23a. Part Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Immediate Ceuse (Finel End stage diseasa or condition rasulting in daath) discar Due to (or es e consequenca of): Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Lest Due to (or es e consequenca of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a Stete

Director

Funeral

þ

Completed

**Funeral** 

Director

permit. Pegas 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Emergence.

Examiner Physician/Medicai p Completed Be

80 Certification: To

physician end s the burief-transit The law requires that the death certificate be executed Records, P.O. Box 68760 attanding p been signed by the should be detached director, page 2 s Division of Vital al or Attending Physician: Tis eftar deeth.

In Director: After this certificet ed in by the funeral director, pa To the Hospital or within 24 hours eft To the Funeral Di completaly filled in

24b. Wara eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy 1 Tyes 2 No 1 Yes 2 DNo 25. Wes case referred to medical 26. Place of Daath (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and dua to tha causa(s) and mennar es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred et the time, data and place, and dua to tha cause(s) end menner steted. 29a. Cartifier (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number-

State Registrar

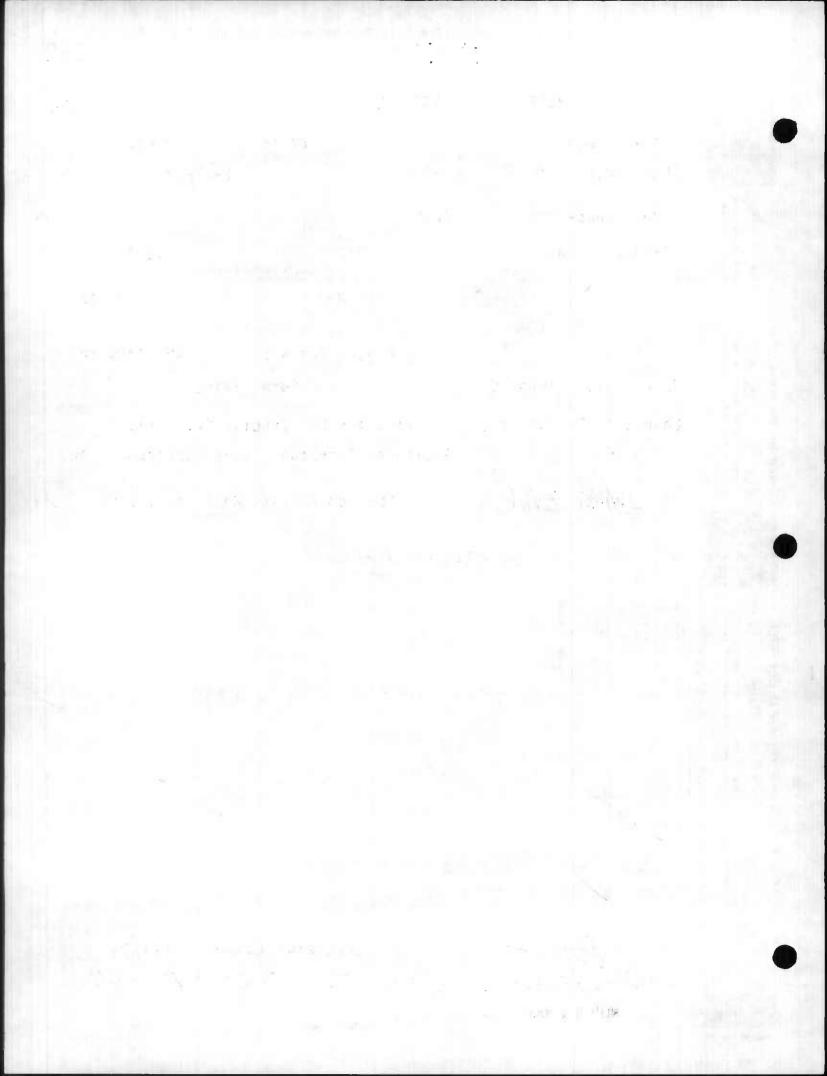
Medical

HAFFMAR 31. Dete filed (Month, Day, Year) 1999

30. Neme end adds

32. Registrar's Signature

ess of person who completed cause of deeth (Item 23e) (Type, Print)



**DHMH 16 Rev 6/95** 

State

Registrar

NOV 0 4 1999

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 99 36291

					Certificate of	f Death	Re	g. No.	36294
Physic	cian	1. Decedent's Neme (First, Middle, La					2. Dete of Death	Day Yes	3. Time of Death
/Med			RABTREE					er 8, 199	9 2115
Exam	iner	4e Facility Neme (If not institution, given SACRED HEART HO				CUMBERI		4c. County of Do	
Funera Directo		217 32 2000	ex 7. Age	63 Y	hday) If Under 1 Yea Months Day		Irs. 8. Date of Birth (Month, Day, JUNE 3		Birthplaca (State or Foreign Country) RYLAND
pue M.		Usuel Residence of Decedent  10a, Stete 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Many Laho	tor	MARYLAND ALLE	GANY	COR	RIGANVILLE				1 ☐ Yes ZX No
r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
after deeth with the Maryler or items 23s or 28s-f show		11115 CHARLOTTE	AVE.		215	24		U.S	.A.
ep .	Funeral	11. Meritel Status	12. Wes Decedent E Armed Forces?	Ever in U,S.	13. Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indien, hite, etc.
2-00.20 72 hours after deeth with the Marylend natural, or Nems 23s or 28s-f show	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Detes: I		1 ☐ Yes 2 💢 N			Specify:	
n 72 hours	etec	15. Decedent's E- (Specify only highest gra	ducation de completed)	16a.	Decedent's Usuel Occ (Give kind of work don life. DO NOT use retii	upetion e during most of t	working	6b. Kind of Busine	ss/Industry
filed within Hygiena. ther then	Completed	Elementary/Secondery (0-12)	College (1-4or 5	+)	INESS AGEN			· A D DEMTED	S LOCAL 1024
be filed that Hygie d other avant, tr		17. Father's Neme (First, Middle, Last,		[ ]	INESS AGEN		Name (First, Middle, N		5 LUCAL 1024
Mental Mental	o Be	JOSEPH CRABTREE				HELEN	WILKENS		
d2 sh d2 sh th end 7 is m traum	-	19e. Informant's Name/Relationship ( DORIS CRABTREE	Type, Print) WII		Meiling Address (Street BOX#245		Rural Route Number. E, MARYLAN		e, Zip Code)
D		20e. Method of Disposition			Disposition (Name of crematory or other p	(aca)	Date 2	20c. Location - City	or Town, Stete
permit. Pages 1 er Department of Hea Important: if item; any injury or other		1 Buriel 2 Cremetion 3 C 4 Donetion 5 Other (Specif	y)		AP VET CEM	ETERY NO	V 12 1999	FLINTSTO	NE MD.RFD
Department of the second of th		21. Signature of Funerel Service Lice	Plerutt	>	22. Name and Add MERRITT-A 404 DECAT		ERAL HOME	P A MARYL	AND
		23a. Pert1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lin	the deeth. Do n	ot enter the mode of d	ying, such as card	diac or respiratory erre	st,	Approximete Intervel Between
Physician									Onset end Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. OAT CE	ELL CH	REINDMA	LUA	JG		7 MONTHS
	9			Due to (or es e c	onsequence of):	•			
Det De pristre	Examiner	Comments the lies are divisor.	b	Due to (or es a c	oneadhaca at).			<u> </u>	i
en en rial-tr		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		Due (0 (0) es a c	orisequence or).				
tificate be executed as the burial-transit	edical	Cause (Disease or Injury that initiated events resulting in death) Lest	c	Oue to (or es e co	onsequence of):				
	- 5	L	d						
es thet the death cert igned by the ettendin be detached for usa	Physician/						l an mus		1
	hysi	Pert II. Other significant conditions of	Λ		the underlying cause (	jiven in Pert I.	236. Did to	1.0	ute to the cause of death' Probably 4 Unknow
ned b	by P	BILATERAL	PNEUMO	NITIS			_	290110	Trobably 4 Dimitor
requir should		METASTATIC (	) ISEASE	TO THE	-BONZ,	DRULL	24a. Wes er perform		b. Were eutopsy findings evailable prior to completion of cause of death?
F # 8	Completed	200	BRAIN				1 □ Ye	s 2000	1 Yes 25kNo
Physician: The	Be	25. Wes case referred to medical examiner?	Hospitel:		lo	Wher	Death (Check only on		
- S S	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day		patient 3LI DOA	4⊔ Nursin ury et ork?	g Home 5 Reside		pecity)
oding : Afte e fun	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		Year) In		ork? □Yes 2□No			
I or Attanding aftar death. Director: Aftel d in by the fune	Certification:	3 Suicide 6 Could not b determined	28e. Plece of Injubuilding, etc	iry - At home, fan . (Specify)	m, street, factory, offic	9	28f. Location (Str City or Town		Rural Route Number,
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of and menner sta	examination end	deeth occurred at the /or investigation, in my	time, date end pin opinion, death o	ace, and due to the ca courred et the time, da	use(s) and menner ite and place, end	es stated. due to the cause(s)
o the	¥ €	29b. Signeture, and title of certifier			29c. Lice	nse number	25	d. Date signed (Me	onth, Day, Year)
F3F8		11/2	(). 1C	Made a	0 0-	1486	-	Iorra-b	1000
/		30. Name and address of person who	completed cause of de	eath (Item 23a)	ype, Print)	1100	2 1	November	7, 1999
ne	8	DR R. BARRERA				BUILDING	CUMBERLAN	ND MARYLA	ND 21502
St	tate	31. Dete filed (Month, Day, Year)	2. Registre	r's Signeture	land	,			
Regist	trar	NOV 1 0 1999	Contract of the contract of th	10	sparks				

400 10 1900 person to aprecio

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36295 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month Physician 755 NOVEMBER Ruth D. Clark /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center Baltimore If Under 24 Hrs. 8. Data Baltimore If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Funeral Days Months Hours 1□M 200 F 72 Yrs. 213-24-4245 Director Virginia Jan. 13, 1927 Usual Rasidence of Decedent the Meryland 10a Stata 10b. Counts 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Exercises must be notified at pine. MD 1 X Yas 2 □ No Baltimore Baltimore Director 10e Street and Number 10f Zin Code 10g. Citizan of What Country? 324 Melvin Avenue 21228 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or Nott Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U.S. Armed Forcas? 1 Nevar Marriad 2 Married 1 Yas 2 No If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) House Keeper Hotel Service 7.th 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Roland Stephens Pinkie Stephens 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 324 Melvin Ave. Baltimore, MD Randolph Clark/Husband 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata MD Thompsontown Cem. 11 - 64 □ Donation 5 □ Othar (Specify) Thompsontown, 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility Framptom-Hawkins-Eskow Funeral Home 216 N. Main St.Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final comem disaasa or condition resulting in deeth) Examiner Dua to (or as a consequence of) Examiner physician end the burial-trensit certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaase or injury that initiated avants resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of) 88 980 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Ware autopsy tindings available prior to should 24a. Wes en eutopsy performed? Completed complation of causa of death? page 2 s 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was casa rafarred to medicat axaminar? 26. Place of Death (Check only ona) STE//A MARIS AT MERCIV Be Other: 4 Nursing Homa 5 Residence 6 Mothar (Specify) HOSpicE To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After it completely filled in by the funera Certification: 28b. Time of 28c. Injury at Work? After ! Natural 5 Panding invastigation 2 Accident 1 Yas 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Medical <del>付 Cartitying Physician</del>: To tha best of my knowledge, deeth occurred et tha time, date and place, and dua to tha cause(s) and mannar es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and titla of certitian 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (ttern 23a) (Type, Print)

State Registrar

DAVID 31. Data filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

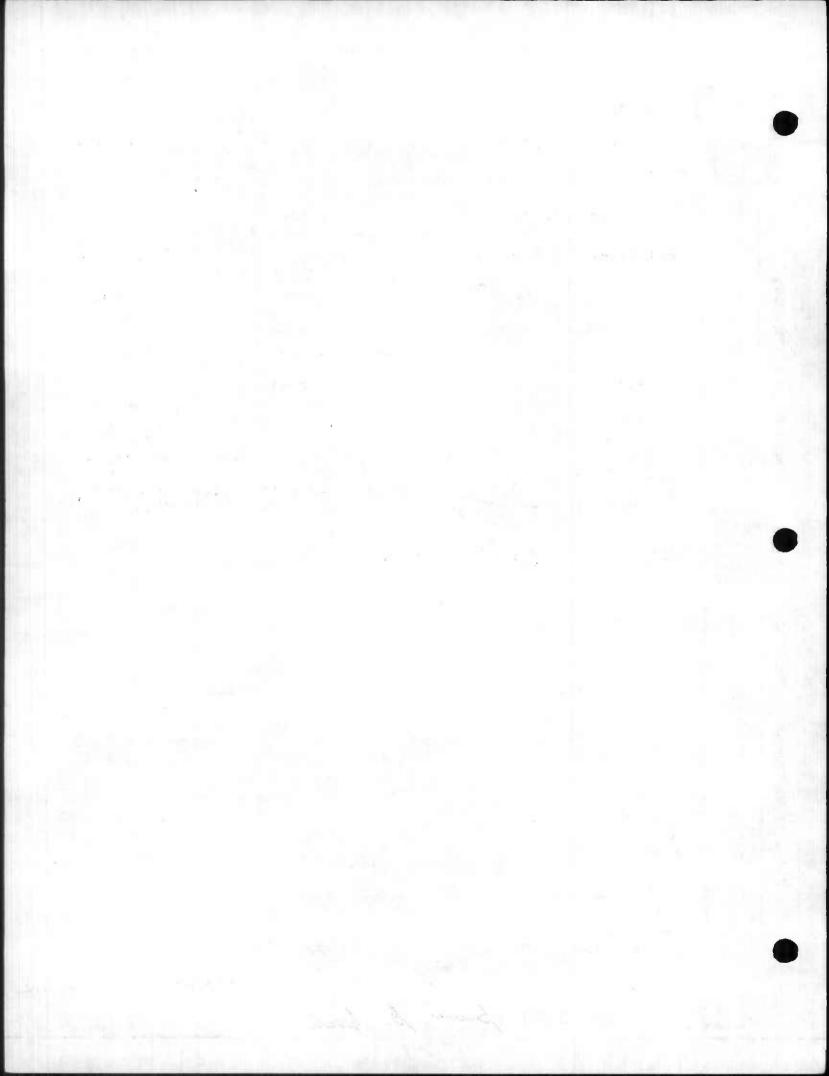
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32. Registrar's Signatura

BA/tiMORE

RISEDERG

NOV - 9 1999



99-6767-001 DDG KEVIN M. CLARK

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ 35296

AMEND IT	TEMS: #23 PART I  1. Decedent's Name (First, Middle, Last Kevin Michael Clark		Certifica	ate of Dea	2. Dete of I		3	3. Time of Death 524
/Medical Examiner	4a Facility Neme (If not institution, give SACRED HERAT HOSPI				Town, or Location of De MBERLAND	ath 4c. County	y of Death LEGANY	
Funeral Director	210-70-0770	x	last birthday) If Unit Month		dar 24 Hrs. 8. Date of E rs Min. (Month, I 1.5-Ju		9. Birthplac Country Marylar	se (State or Foreign ) nd
Maryland and show tried at	Usuel Residence of Decedent 10a. State 10b. County  Maryland Garrett		ty, Town or Location				10d.	. Inside City Limits  1 Yes 2 No
23e or 28e-f e		el Road		Zip Code 1532-		10g. Citizen of U.S.A.	What Country	?
within 72 hours effer deeth with the Manyland ens. than "natural", or items 23s or 28s-f show the Madell Energies must be notified at ampleted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evar in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:		pedent of Hispanic pecify Cuban, Mex 2 No Spec	Origin? (Specify Yes or I can, Puerto Rican, etc.) ify:	No- 14. Rad Ble Specif	ce - American eck, White, etc. nite	
Mary land A 12.15-0020 d 2 should be filed within 72 hours eit it and Marial Hyghen. It is marked other than "natural", or thoumatic event, the Madiell Enter To Be Completed by F	15. Decedent's Edu (Specify only highest grad		16a. Decedent's U (Give kind of life. DO NOT OSSISTANT C	work done during n use retired)	nost of working		Business/Indus	
be filed dother went, is	17. Father's Neme (First, Middle, Last)				other's Name (First, Midd			
2 should be and Mentel 16 marked of our and Mentel 16 marked of our and 17 o B	Paul G. Clark			Eve	lyn Wilhelm			
ode :	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailing Addre	ass (Street and Nu	mber or Rural Route Nun	nber, City or Town	i, Stata, Zip Co	ode)
1 and 2 Health em 27 in	Paul G. Clark	Father	1042 Finzel I	Road	Frostburg	Mary	land 21	1532-
2550	20a. Method of Disposition  1  Burial 2 Cremetion 3 F  4 Donetion 5 Other (Specify)	Removel from State	Place of Disposition (formatory of cemetery, cramatory of cel Cemetery	leme of r other place)	Defe 5-Nov-99		- City or Town aryland	, State
permit. Pego Department of Important: If eny injury of phos.	21. Signefure of Funerel Sarvice Licens	Durch		end Address of Fe uneral Hon	ne, 57 Frost Ave	., Frostburg	J, MD 21	532
Medical Examiner of the burst-transit Medical Examiner of the burst-transit Medical Examiner of the burst-transit	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Dua to (c	LEROTIC or as a consequence of	of):	ASCULAR D	ISEASE		
2 2 5	Cause (Disease or Injury that initiated events resulting in death) Last		or as a consequence o	<b>()</b> :				
es that the deeth certificated by the etending be detached for use by Physician/M	Part II. Other significant conditions con DIABETES MELL		sulting in the underlying	g cause given in Po		d tobacco use co	ontribute to th	bly 45 Unknow
been s should						es en eutopsy rformed?	aveila	a eutopsy findings able prior to eletion of cause ath?
physicien: The lever this certificate has all director, page 2.  To Be Comp					1 6	Yes 2 No	120	(es 2□ No
entifica ector.	25. Wes case referred to medical examiner?				aca of Death (Check onl	y ona)		
Physicien: this certific ral director.	1 XXes 2 No		∰R/Outpatient 3□		Nursing Home 5 ☐ Re			
tal or Attending Physicien: Tre effections. To all Directors After this certifical ied in by the funeral director, p	27. Manner of Deeth 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury M	28c. Injury at Work? 1 ☐ Yes 2	□No	e how injury occu		
ottal or Att urs effer d real Direct lied in by	4 Homicide detarmined	28e. Place of Injury - At he building, etc. (Specif	(y)		City or 1	(Street and Num fown, State)		
he Hospi in 24 hou he Funer pietely fil		sician: To the best of my kno ner: On the basis of examine						
To the Hospital or within 24 hours of the Tornes Director of the Compietely filled in Medical Cert	29b. Signatura and fitla of certifier	end menner steted.	1	29c. Licansa numb	er.M.E.	29d Date signe NOVEM	ad (Month, Da BER 12,	y. Year) 1999
Sel	30. Name and address of person who co	empleted cause of deep (tren	PENN STRE	ET BALTIM	ORE, MARYLA	ND 21201		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature 4	Asa v				

93 Mar.

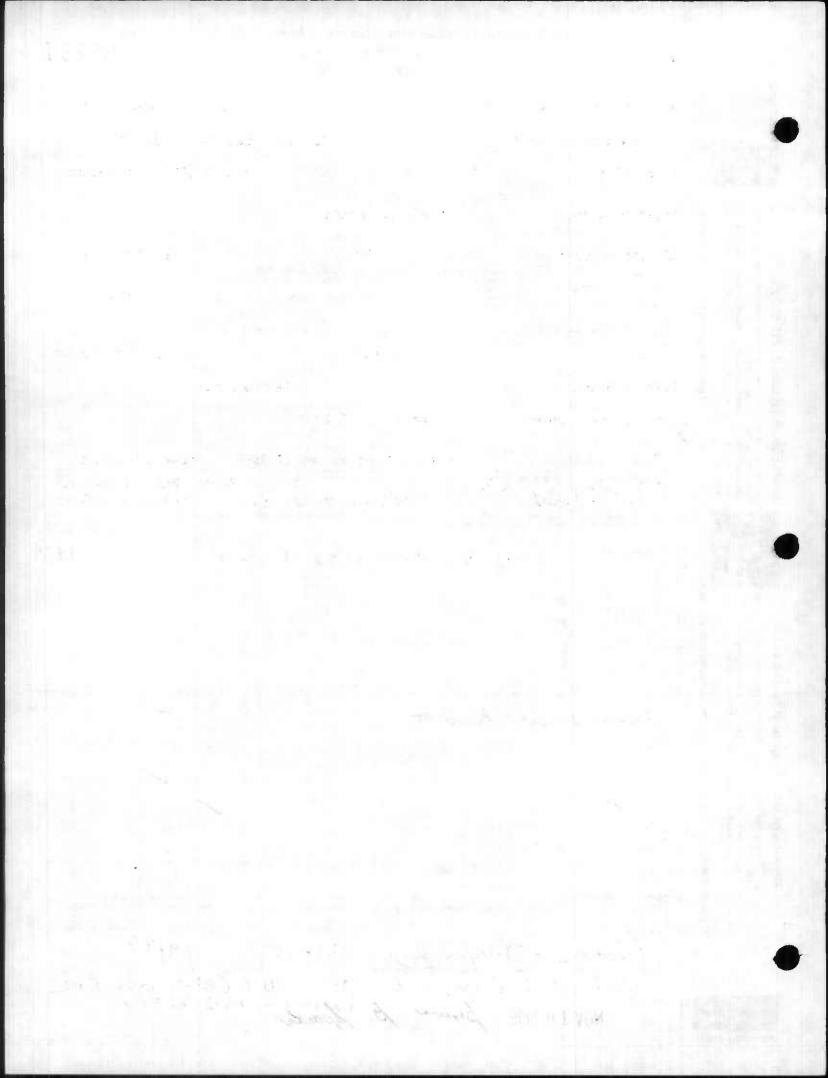
COVI 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 3 6 2 9 7

Certificate of Death

				Certif	ficate of	Death			Reg. No.		
	1. Decedent's Name (First, Mic	idle, Last)						2. Dete of De		Miles	3. Time of Deeth
Physician	Clara Bell	e Bowen	Cox					Month NOV	8 199	Yeer 9	7 pm
/Medical Examiner	4e Fecility Neme (If not institut	ion, give street end n	umber)			4b. City, To		cation of Deatl	1		, ,
CAdminer	5464 Sixe	es Road				Prince	e Fre	derick	Calve	ert	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. lest b		Under 1 Yea		24 Hrs.	8. Date of Bir	th	9. Birthp	lece (State or Foreig
Director	212 36 3934	1 M 2 F	78	Yrs.	fonths Dey	s Hours	Min.	Aug 21	1921	Mary	land
	Usuel Residence of Decedent										
ehow dat	10a. State 10b. Coun	•	10c. City, Tov			1				1	0d. Inside City Limit:
rector	Maryland Calv	ert	Prin	ce Fr	ederic	K					1 Yes 2 N
or 28a-f	10e. Street end Number				10f. Zip Code				10g. Citizen of V	Vhet Coun	itry?
38.0	5621 Sandy Poi	int Road			20678				United	Stat	ces
r items 23s or 28s-f e drar must be nothed Funeral Director	11. Marital Status	12. Was De	cedent Ever in U,S.	13. Was	s Decedent of	Hispanic Orl	Igin? (Spe	cify Yes or No		e - Americ	
		arried 1 Tes	2 🛛 No		Yes 2XN			moan, oro.)		whit	
3 6		ed If Yes, C	Detes:	10	ITES ZIZIN	u Specity.			Specify	. AATIT(	
t, tra Medical Exe Completed by	15. Deced	ent's Education		Decedent	t's Usuel Occ	upation	et of working	10	16b. Kind of Bu	siness/Ind	dustry
Med dr	Elementery/Secondary (0-12	hest grede completed  College	(1-4or 5+)	life. DO	d of work don NOT use reti	red)	or work!	'9			
E O	12			secre	tary				Dept. o	f Agr	riculture
event, Be C	17. Fether's Name (First, Middl	le, Last)				1000			, Maiden Sumen	e)	
0	Alvin B. Bower	1				Ett	a She	eckells	5		
-	19a. Informent's Name/Relatio			_			er or Rure	l Route Numb	er, City or Town,	Stete, Zip	Code)
	Oliver S. Cox-	- husband	S	ameas	#	10					
any injury or other tra	20e. Method of Disposition		cemet	of Disposition	on (Name of ony or other p	lace)		Dete	20c. Location -	City or To	own, Stete
any injury or once.	1 Burial 2 Cremetion 4 Donetion 5 Other		Centr	al Ce	metery	Nov 1	1 19	99	Barstow	Mary]	Land
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any ir	DAC	RULOC		1405	Proom	oc Te	Ба		Republic		
	23a Pert1. Enter the disease	or complications that	caused the deeth. Do							LID 2	Approximete
	23a. Pert1. Enter the disease, shock, or heart failure. L	ist only one ceuse or	eech line.			,,		,			Intervel Between Onset end Deeth
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rector, page								10	Yes 2 No	18	☐Yes 2☐No
director.		cal				26. Plec	e of Death	(Check only	ene)		
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the funar	2 Accident inve	stigation				Yes 2	No				
by th	3 Suicide 6 Coul	ld not be emined 28e. Ple	ce of Injury - At home, ding, etc. (Specify)	arm, street	, factory, offic	е	1	28f. Location (	Street end Numb wn, State)	er or Rure	el Route Number,
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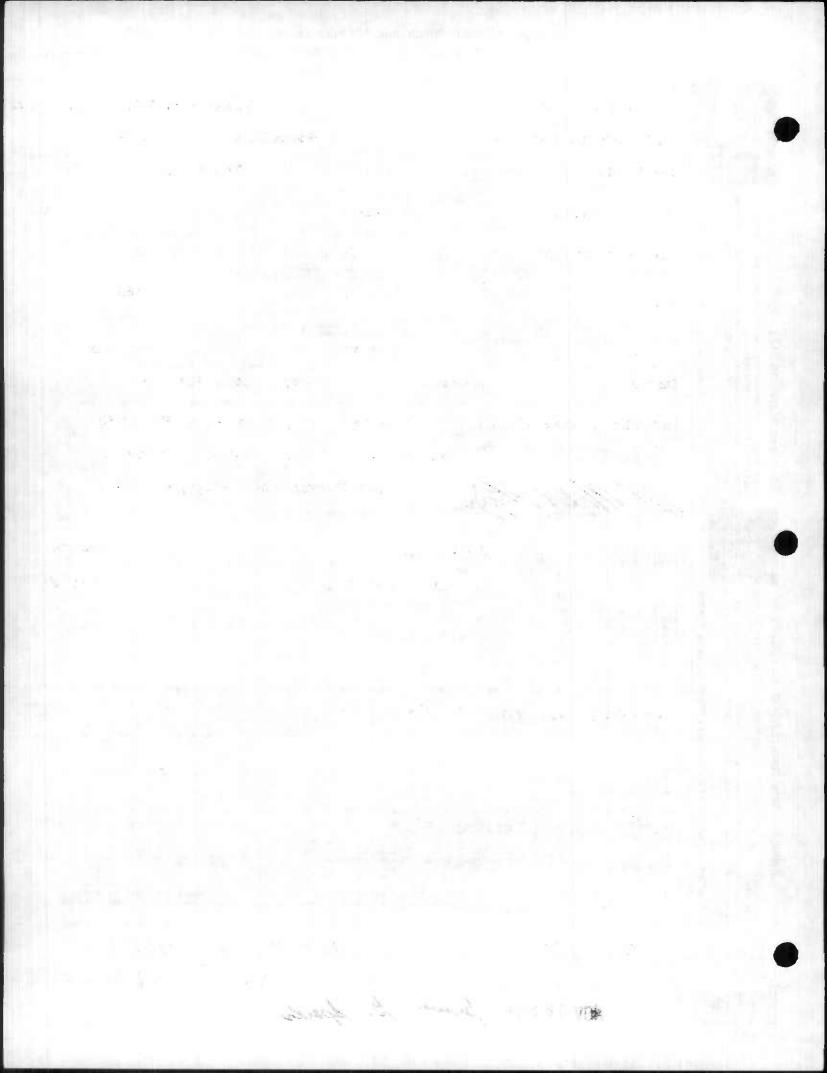


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State of Maryland / Department of Health and Mental Hygiene 99 36298

				Cei	rtificat	e of	Death		Reg	g. No.		629	U
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tor	10e. Stata 10b. County MD Calver	rt	10c. City	, Town or Lo Sund	ecation derlar	nd					1	0d. Inside C	ity Limits
i Director	10e. Street and Number 520 Lower Marlbo	oro Road			10f. Zip	Code 2068	9	H	10	g. Citizen of US		ntry?	
a paradura	11. Maritel Stetus  1 Never Married 2 Married  3 Nover 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Yeer or Detes:				dent of h	Hispanic Orig an, Mexicen,	in? (Speci Puerto Ri	fy Yes or No- can, atc.)	Ble	ce - Amano ck, White, white	etc.	,
-	15. Decedent's E (Specify only highest g	Education rade completed)		16e. Deced	dent's Usu kind of wo	al Occup	pation during most d)	of working	10	6b. Kind of B	usiness/Ind	dustry	
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	Daniel	Ha	ardes	ty			Mary	C	atherin	e Dr	ury		
	19a. Informent's Neme/Reletionship	(Type, Print)		19b. Mailir	ng Address	(Street	end Number	r or Rurel I	Routa Number,	City or Town	Stete, Zip	Coda)	
	Lorraine C. Hend	ck (daug.)					Dr.,	Punt	a Gorda				
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	4 ☐ Donetion 5 ☐ Other (Spec		Mt	. Harm	nony I	JM C	hurch	111	-10-99	Owin	gs, N	AD	
	21. Signature of Funeral Service Lice	nnsee					ess of Fecility		Owings	MD	20736	5	
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	shock, or heert failure. List only	mplications that sauser y one cause of each ti	the death	. Do not ent	er the mod	de of dyi	ng, such as o	cerdiac or i	raspiratory erres	st,		Approxime Intervel Be Onset and	le lween
	Immediate Course (Final												
	Immediate Cause (Finel disease or condition resulting in death)	e. A.	NEM	1 A							/	MONT	45
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									1□ Yes	s 20 No	1[	☐Yes 2□	] No
-	25. Wes case referred to medical axeminer?						26. Plece	of Death (	Check only one	)			
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	2 Accident Investigation 3 Suicide 6 Could not determine	be Diese of In	ury - At ho c. (Specify	me, farm, str					f. Location (Str. City or Town,	eet end Num State)	ber or Run	el Routa Nur	nber,
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 99 36299

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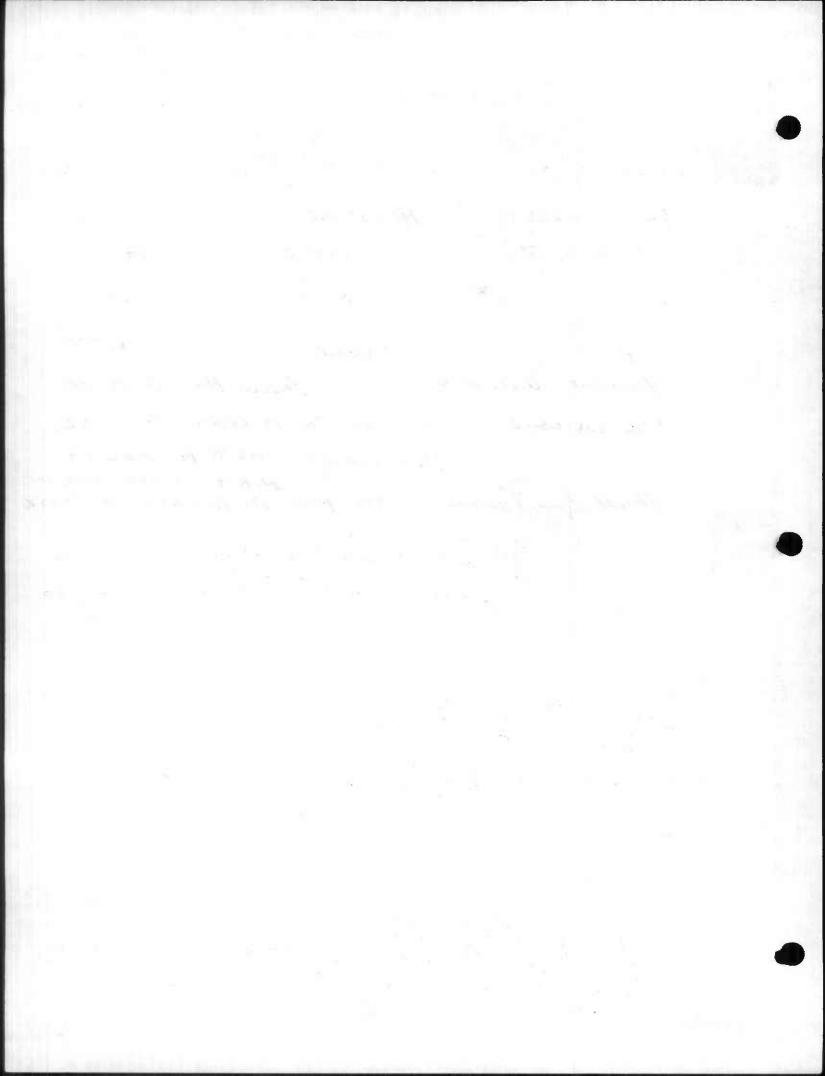
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

36300

_			Certificate of Death		Reg. No.		0000
	Physic: /Medi		1. Decedent's Name (First, Middle, Last)  GALILEO  DI VALENTINO	2. Dete of D Month Nevan,	Dey	Year 949	3:00 A
7	Examir	ner	4a. Fecility Neme (If not institution, give street and number)  GOUDWILL MENNON ITE HOME  4b. City, Town,  GRANTS	or Location of Dea	, , , , , , , , , , , , , , , , , , , ,	of Death	Co.
	Funeral Director		181-29-14 19 DM 201 88 Yrs.	fin. 8. Dete of Bi (Month, D	ey, Year)	9. Birthplec Country	e (State or Foreign
	death with the Marylend me 23a or 28a-f show must be notified at	ector	Usuel Residence of Decedent  10a. State  10b. County  PA  SomeRSET Co  10c. City, Town or Location  MEYERSDALE  10c. Street end Number		10s Chiron of l		Inside City Limits 1 ★Yes 2 No
	h with	i Dir	10e. Street end Number  7 NORTH ST.  10f. Zip Code  1555 Z		10g. Citizen of N		f
020	or ite	by Funeral Director	11. Marital Status  12. Wes Decedent Evar in U,S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No Specify:  1 Yes 2 No Specify:	(Specify Yas or Nuerto Rican, etc.)		ce - American ck, Whita, ato v: WH 17	
215-0020	"natural",	eted	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of life. DO NOT use retired]	working	16b. Kind of B	usiness/Indus	itry
212	filed within Hygiena. Ither than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		CONST	RUCT	YON
land	Mental Mental arked o	To Be C	The management of	Neme (First, Middle ELA MA		CHES	SARI
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Ba	permit. Pe Departmen Important: any infury once.		21. Signeture of Funeral Service Licensee  22. Neme end Addrass of Facility			_	•
	77		23a. Part1. Enter tha disease, of complications that caused the death. Do not enter the mode of dying, such es cerd shock, or heert failure. List only one ceuse on each line.	diac or respiretory	Prast,	A	pproximata tervel Between
ì	Physician /Medical Examiner		Immadiate Cause (Final disease or condition resulting in death)  e. Figure 1. The Control of the	rrhyth	mia	n	nsat end Death
		ner	Dua to (or es e consequence of):  Conyective Heart +	a Que	L	5	71000
, ,	ete be axecuted physician end the burial-transit	i Examiner	Sequentially list conditions, if any, laading to immadieta cause. Enter Underlying Ceuse (Disease or influry c.	7,000	,	(	1
ox 68760,	n certificete be axecuted anding physician end use es the bunal-transit	n/Medicai	that initieted events resulting in death) Last  Dua to (or as a consequence of):				
m		Physician	Pert.H-Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	I tobacco uee co	ntribute to th	e cause of death?
P.0	that tha daath ned by tha attar s detached for u	/ Phy	Coronary Artem Disease	1□	Yes 2 No	3 Probab	oly 4 🗆 Unknown
Vital Records,	requiras been sign should be	Completed by	Diabetes.	24a. We	s en eutopsy formad?	evelle	eutopsy findings bble prior to letion of ceuse
ital Re	The ate h page	0	Chrunic obstructive Ly Discage 25. Wes case referred to medical 26. Place of	1 ☐ Deeth (Check only	Yes 2 No		es 2□ No
of V	Physiclen: this certific ral director,	ToB	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 45 Nursin	g Home 5 ☐ Ras	idence 6 Oth		
lon	th. : After is funer	ation:	27. Manner of Deeth   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury et Work?   2 Accident   Accide	28d. Describe	how injury occur	red	
Division	To the Hospital or Attending Physicien: within 24 hours effer death.  To the Funeral Director: Affer this certific complataly filled in by the funeral director.	Certification:	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)		(Street and Numb own, Stete)	ber or Rural R	loute Number,
	e Hospit 24 hours e Funera	edica! (	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plugger (Check only one)  2. Medical Examíner: On the basis of exemination end/or investigation, in my opinion, deeth or end manner stated.	ece, end due to the ccurred et the time	e ceuse(s) end me , date end place,	enner es state end due to th	ed. e cause(s)
	To the withir comp	Me	29b. Signatura and tille of certifiar 29c. License number	179	29d. Data signe	d (Month, De	y, Year) 999
	nes		30. Name end endress of person who completed cluse of death (item 23a) (Type, Print)	)	5551		. /
	Sta Registr		31. Dete filed (Month, Day, Year) NOV 0 8 1999 32. Registrer's Signeture	<i>1</i> 7			



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State of Maryland / Department of Health and Mental Hygiene 99

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						Ce	rtificate	e of	Death			Reg. No.		00,	001
		1. Decedent's Nama (First, I	Middle, Last)								2. Dete of Dee	eth Day	Yeer	3. Tim	ne of Death
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	/Medical Examiner	4e Fecility Neme (If not Insti		street end num	nber)	1			4b. City, To	own, or L	ocation of Death	7		1	
	Examine	Egle Nursing							Lona	coni	na	7	allega	anv	
		5. Social Sacurity Number	6. Sex		7. Aga (In vrs.	. lest birthday)	If Under	1 Year	If Undar						tete or Foreian
	Funeral Director	213-24-6339 Usuel Residence of Decede	10	]М <b>∦</b> Д F	93	Yrs.	Months	Deys	Hours	Min.	8. Data of Birt (Month, Day Jan. 31	y, Year) .,1906	Mary.	land	tete or Foreign
land	ž 11	10a. State 10b. Co			10c. C	ity, Town or Lo	ocation						1	10d. Insid	de City Limits
with the Maryland	10 P	um					n							XD	Yes 2 □ No
9	be notified Director	MD 10e. Street end Number	Allega	iny			10f. Zip	ctor.	1			10g. Citizen of	Whet Cour	ntry?	
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72 hours after de	ar, or items 23e or 25e-t show Examiner must be notified at by Funeral Director	11. Meritel Stetus  1 Never Married 2  3X Widowed 4 Divo	Married	12. Wes Dece Armed For 1 Yes If Yes, Give Year or De	ces? 2 <b>∑</b> No a	),5. 13.	was become if Yes, spec		en, Mexicar Specify:		ecify Yas or No- Rican, atc.)	Ble	ck, White,	etc.	
12 70	"natural", edical Exa		edant's Edu			16e. Dece	dent's Usua	Occup	oation			16b. Kind of B	usiness/in	dustry	
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D D	80 0	Truman Wilt							Luver	nia F	Bittinge	r			
nous	The Party	19a. Informent's Neme/Rela	tionship (Tv	pe. Print)		19b. Meili	ng Address	(Street			rel Route Numbe		Stete, Zic	o Code)	
20	10000000000000000000000000000000000000	Lucinda Bows									in St.,				21539
	94.5	20e. Method of Disposition	CL/ DI	JUCE	20b.	Place of Dispo		-	, 012	- 1101	Date	20c. Location			
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permit, Pages 1 a	import any in ance.	21. Signature of Funaral Sa	rvice Licensi	ae /							man Fur 30x 275,				
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Dh	ucicion	shock, or heart feilure.	List only or	ne ceuse on ee	ech line.								į	Onsat :	and Death
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i or Attending Physician: The law requires to	d bi											en eutopsy	24b. W	/ere euto	psy findings
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d B	Aftar th funeral	27. Menner of Death 1 Neturel 5 □ P	ending	28e. Dete o	f Injury h, Dey Yeer)	28b. Time o	of 2	8c. Inju Wo	ry et rk?		28d. Describe	how injury occu	rred		
Attending	atic	2 Accident in	vestigation		,,	,,,,,,	М		Yes 2□	) No					
or Atte	ai Director: After t led in by the funera Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)							28f. Location (Street end Number or Rural Route Number, City or Town, State)					Number,	
To the Hospital or Attend	mining the Funders all obserts.  To the Funders Director: After this certificate he completely filled in by the fundral director, page Medical Certification: To Be Com												use(s)		
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	1	ALV	Me	1 1	M)			DI	570	04		nou,	1, 19	99	
		30. Name and address of pe	rson who co	mpleted cause	of death (Ite	m 23e) (Type.	Print)								
				,			,								

57 JACKSON ST. LONACONING MD 21539

DHMH 16 Rev 6/95

nes State Registrar

L.R. MILES JR. M.D.

31. Dete filed (Month, Day, Year)

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99-6363-047 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. mnmr State of Maryland / Department of Health and Mental Hygiene 36302 UNKNOWN #99-252 JOHN L. DAVIS AMEN AMEND#23a,27-28f PER M.E.O. G777 11-22-9 Gertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John L. Davis October 22, 1999 3:55 a.m. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Md. Rt. 589, South of Manklin Creek Road Ocean Pines Worcester 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 100 M 2□ F Months Hours 30 Director May 13, 1969 MD Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show 1 Yes 2X No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11805 Sinepuxent Rd. 21811 U.S. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. d 2 should be filed within 72 hours after ith end Mental Hygiene.
7 ie marked other than "natural", or flei traumatic event, the Medical Examina 1X Never Merried 2 ☐ Merried 21215-0020 Specify: Black 1 ☐ Yes 2 XNo Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 Cook Restaurant Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 and 2 should be filt mant of Haalth end Mental Hant: If item 27 is marked oth jury or other traumatic even Be John Pierce Clarenda Davis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Clarenda Davis/mother 11805 Sinepuxent Rd., Berlin, MD 21811 20b. Plece of Disposition (Name of cometery, crematory, or other place)
Calvary Pentecostal
Church Cemetery 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ⊠ Burial 2 □ Cremetion 3 □ Removel from Steta Department of important: If any injury or other 4 ☐ Donetion 5 ☐ Other (Specify) 10/30/99 Bishopville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD Approximate Interval Between Onset end Death Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical MULTIPLE INJURIES Examiner Due to (or es e consequence of) Physician/Medical Examiner ician and bunal-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disaase or injury that initieted avents resulting in deeth) Lest Due to (or es e consequence of): Box 68760, physician s tha buna Due to (or es e consequence of): 98 usa signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 3 Probably 4 Unknown 1 Yes 2 No Records. ò The law requires 24b. Were autopsy findings available prior to should I Completed 24a. Wes an eutopsy performed? completion of cause of death? paga 2 UNYes 2□No 12 Yes 2 No of Vital Physician: 25. Wes casa referred to medical axaminar? Be 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) At Scene Certification: To XXYes 2□ No this funeral 28d. Describe how injury occurred 27. Mannar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury at Work? Division or Attending 1 Neturel MOTOR VEHICLE ACCIDENT 1 Yes 2 No 3:55 A. M r death. investigation 10/22/99 2 K KAccident 24 hours after deat Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Steta)RT. #589 AND OCEAN PINES filled in by 4 Homicida STREET WORCESTER CO. MD. Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar Tabler

0°2 1999

5,

30. Name end address of parson who completed cause of deeth (Item 23a) (Type, Print)

Radentz

DUME

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

October 23, 1999

Land Harrison

2)11/2 [ 2/11/2]

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 19-0 36303 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** ELSNETZ 728 BROTHY 11 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMULE BALTIMORE UNIVERSITY OF MARYLAND Hours Min. B. Data of Birth (Month, Day, Year) Aug. 16, 1912 Mary Land 9. Birthplace (State or Foreign 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 10 M 20 F 217-48-8284 Director Usual Rasidance of Decedant 10a. Stata 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Tyes 2 XNo Director Havre de Grace 230-1 Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 114 Southway Drive 21001 U.S.A. Name 25a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No II Yes, Giva Yaar or Datas: 14. Race - American Indian, 11 Marital Status Black, Whita, etc. 72 hours after 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 'natural', or 1 Yas 2 No Specify: Specify: White by 31☑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home Pages 1 and 2 should be filed nant of Health and Mental Hygis int: If Nem 27 is marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Solomon Gosweiler Emma Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Joan E. Hamilton (Daughter) 114 Southway Drive, Havre de Grace, Maryland 21078 20a. Mathod ol Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data N Burial 2 □ Cramation 3 □ Ramoval Irom Stata 4 □ Donation 5 □ Other (Specify) Paul's Lutheran Cemet 11/4/99 Aberdeen, Maryland 21. Signatura of Funeral Sarvice Licensee 22. Nama and Address of Facility Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Suney Aberdeen, Maryland 21001-3399 Approximata Interval Betw Onset and Death **Physician** /Medical Immediata Causa (Final diseese or condition rasulting in death) SEPSIS Examine Dua to (or as e consequence of): Examine physician and the buriel-transit tha deeth certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Undarfying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medicai Dua to (or as a consequence of) 80 980 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The lew requires that Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 25 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: 25. Was casa ralarred to medical examinar? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas EN Nnpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Data ol Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural 5 Panding Invastigation 1 ☐ Yes 2 ☐ No hours after death. Director: / 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) 2 4 Homicida To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Ecritifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end menner as stated. edical 29a. Certifiar 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title 29c. License number 29d. Data signed (Month, Day, Year) 2.10 30. Name and andress of person who complated cause of death (Item 23a) (Type, Print) Univ. of MD Med. Ctr., 22 S. Greene St., Baltimore, MD 21201 M.D. Heui Yoo, 31. Data liled (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

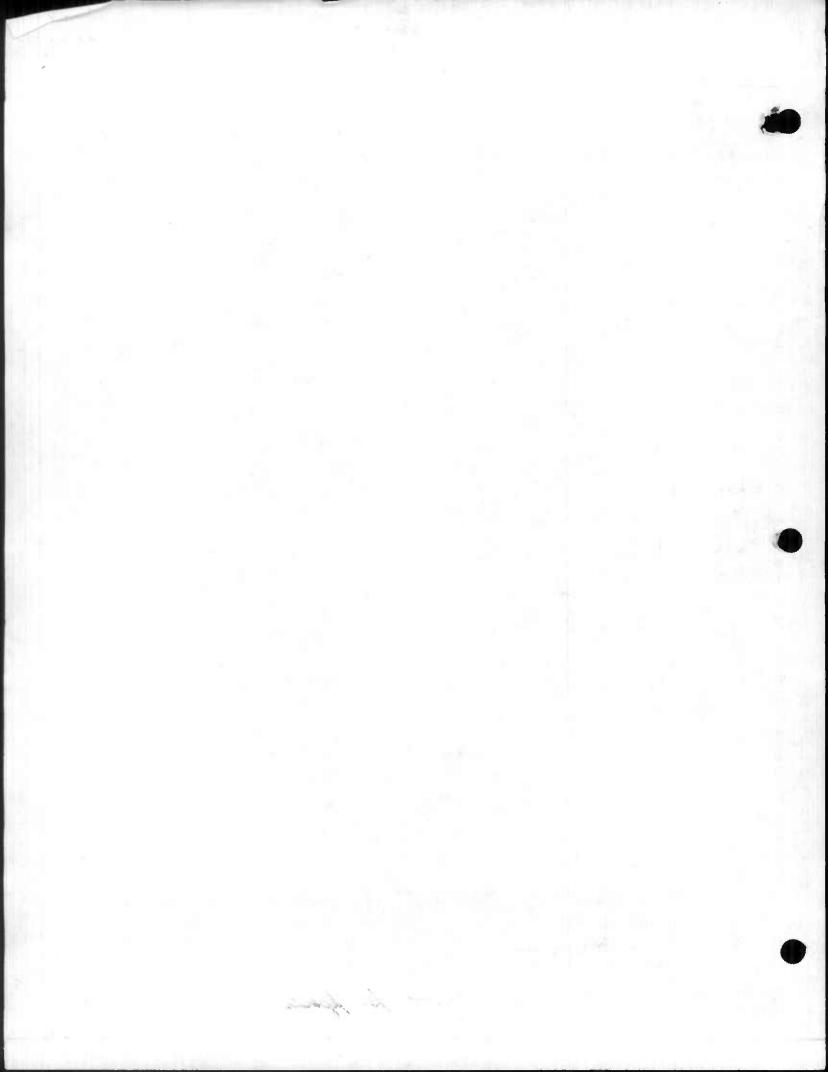
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						Ce	rtificate	of	Death			Reg. No.		•
Physiciar /Medica	1	Decedent's Name (First, Mic George	ldie, Le	st) Edward	i	Elli	.s				2. Dete of De		999 <sup>y</sup>	3. Time of Death 09:18am
Examine	_	4e. Fecility Name (If not institut Cumberland							4b. City, To		ocation of Dear	th 4c. C	ounty of	Deeth Allegany
Funeral Director		5. Social Security Number 218-16-3699	6. S	ex M 2□ F	7. Age (In yrs. <b>7</b>	7 Yrs.	If Under 1 Months	Year Deys		24 Hrs. Min.	8. Date of Bi	rth 8 <sup>y</sup> , <sup>Yea</sup> 1 9	22	Birthplece (State or Forei County)
ath with the Maryland 23a or 28a-f show ust be notified at				egany	10c. Ci	ty, Town or L	wling							10d. Inside City Limi 1 ☐ Yes 🌠 N
ifier death with tha Ma r Items 23a or 28a-f s inner must be notified	2	10e. Street and Number  Bloomingfie	ld	Traile	er Pk		10f. Zip C	ode	21	557			SA	at Country?
s after dea	2	11. Maritel Status  1 □ Never Married 2 → M  3 □ Widowed 4 □ Divorce		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Do	2 TNo		Was Deceder If Yes, specify 1 ☐ Yes	/ Cub	en, Mexicar	gin? (Sp , Puerto	ecify Yes or N Ricen, etc.)		Bleck,	American Indien, White, etc.
as 1 and 2 should be filed within 72 hours of Health and Mantal Hygiane. Item 271s marked other than "natural", r other traumatic event, the Medical Exp.	ombiere	15. Deced (Specify only high Elementary/Secondary (0-12	est gra		-4or 5+)	16e. Deca (Give life. Reti	dent's Usual ( kind of work DO NOT use red	Occup done retire	petion during mos ed)	t of work	ing			mpany
id be filed antal Hyg ked other ic event,		17. Father's Neme (First, Middle Albert E. E							18. Mothe		e (First, Middle M (Bu	, Maiden S Irall		
end 2 shou saith and M n 27 is mark		19e. Informant's Name/Reletic Violet Mae wife 20a. Method of Disposition	nship (	Type, Print)		19b. Meili P.O.	ng Address (S	26	3; Ra	er or Rur Wli	ngs, N	ner, City or	Town, Sta	ate, Zip Code)
permit. Pegas 1 end Dapartment of Health Important: If Item 27 any Injury or other tr once.		1 Daurial 2 Cremetio 4 Donetion 5 Other 21. Signature of Funeral Sovie	(Specify to Licen	S. Sca	AOOO	stlaw	2Scarp Cumbe	or el	ial 11 formand,	une: Ma:	d11/05 ral Ho ryland	me P		, MD
Physician /Medical Examiner		23a. Pert1. Enter the disease, shock, or heart fellure. L Immediate Ceuse (Finel disease or condition resulting in deeth)	or comp	e.	Aspiva	tusn or as e conse	Pres	of dyi	ing, such es	cardiac	or respiratory e	errest,		Approximate Intervel Between Onset and Death
cartificate be executed and inding physician and use as the buriel-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last	{	b		or es e consec								
at the death d by the atta eteched for		Part II. Other significant condi	ions of	ontributing to de	ath but not res	ulting In the u	inderlying cau	se gir	ven in Pert f			tobecco us		bute to the cause of deat
s b		Chromic &	by	triction	e Pu	lmon	my d	i's	care			s en eutops; ormed?	2	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
cartificeta he rector, page		25. Wes case referred to medic	al						26 Place	of Deat	1 [	Yes 20	No	1 ☐ Yes 2 ☐ No
ding Phys h. Aftar this funaral di		E COORDIN	tigation	28e. Date of (Month)	npatient 2 f Injury n, Dey Year)	ER/Outpetier 28b. Time of fnjury		. Inju	her: ANU	rsing Ho	me 5 Res 28d. Describe	idenca 6		(Specify)
		3 Suicide 6 Coul 4 Homicide dete	d not be mined	28e. Pieca	of Injury - At he g, etc. (Specif	ome, ferm, str	reet, factory, o	ffice			28f. Location ( City or To	(Street end wn, State)	Number	or Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert		29a. Certifier (Check only one) 1 Certify 2 Medica	ing Phy f Exam	ysician: To the inner: On the ba end menn	sis of examina	wledge, deati tion end/or in	h occurred et vestigation, in	the tir	me, date en opinion, dee	d place, th occurr	and due to the red et the time,	cause(s) a dete end p	nd menne lace, and	er es stated. I due to the cause(s)
To th To th Comp		29b. Signeture end title	or y	ma					se number					Month, Dey, Yeer)
Mes		30. Name and address of parso Sunil K. Gu		M.D.				е	Cumb	erla	and MI	215	02	
State Registrar	3	31. Dete filed (Month, Day, Yea	0 1	5 1999	egistrer's signa	tyre.	B.	4	ones	1				

Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 36305 Certificate of Death

						Cei	rinicale	9 01	Death			Reg. No.		
п	Physic	ian	1. Decedent's Name (First, Middla,								2. Dete of De Month	ber 7,		Z:50p
	/Medi		Delano Donald  4a. Facility Name (If not institution, g		um <i>her</i> )				4h City To	own or l	ocation of Daati		y of Death	2.301
1	Exami	ner	Sacred Heart Ho		umbery				Cumbe				Legany	
	Funeral			Sax	7. Aga (In yrs. la	ast birthday)	If Undar				8. Data of Bir	th Voor	9. Birthplace	(State or Foraign
н	Director		220-32-2730	1 <b>X</b> M 2□ F	64	Yrs.	Months	Days	Hours	Min.	8. Data of Bir (Month, De May 5,	1935	Mary1	
	pud *		Usuet Residance of Decedent  10a. Stete 10b. County		10c City	Town or Lo	cation							
	be filed within 72 hours efter death with the Maryland that Hygiene.  Id other than "natural", or items 23s or 28s-f show event, the Medical Exercites must be notified at	Funeral Director		merset		lersbu								Inside City Limits  1 ☐ Yes ※※No
	ith th	Dire	10e. Street end Number				10f. Zip					-	What Country?	
	ath w	-E	Rt 160 #14889				155						State	
	item item	un	11. Marital Status	Armad F		3. 13.	Was Deced If Yes, spec	ent of ify Cut	Hispanic Or oan, Mexice	igin? (Sp n, Puerto	ecify Yes or No Rican, atc.)	- 14. Ra Ble	ce - Americen i eck, White, etc.	ndian,
020	urs eft	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	HVOO C	2□No liva Dates: 1965		1□Yas 2	<b>K</b> No	Specify:			Speci	y: White	e
21215-0020	72 ho	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usua	l Occu	pation	at of work	cina	16b. Kind of E	Bustness/Indust	ry
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7	lled v lygie her ti		1.2 17. Father's Neme (First, Middle, La	-41		Manag	ger		40 84-45	sala Maran	- (Final Adida)			
Maryland	S E S	o Be	Lester Calvin En								e (First, Middla, ce Alvei			
ary	shoul nd M	4	19a. Informant's Name/Ratationship			19b. Meilir	ng Address	(Stree	t end Numb	er or Rui	rel Route Numb	er. City or Town	n, Stete, Zip Coo	de)
_	s 1 and 2 should f Health and Men tem 27 is marke other traumatic		Nellie Emerick,				30x 15		Welle	ersbu	irg, PA	15564		•
ore,	of He item		20e. Method of Disposition		20b. Pla	ace of Dispo	sition (Nem	e of	OCO) NT	1	Date	20c. Location	- City or Town,	Stata
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spe		Rest	Lawn 1	Memori	Lal	Garde	ens	er 10,19	1 aVala	, Maryl	and
alt	permit. Pa Departmen Important: any Injury once.		21. Signeture of Funeral Sarvice Lic	ensee Rober	+C. Adams				ess of Facili		-		, IIII	
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			23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that ly one ceuse on	caused the death.	Do not ent	er the mode	of dy	ing, such as	cardiac	or respiretory e	5545 rrest,	Ap	proximeta ervel Between
	Physician												On	set and Deeth
	/Medical Examiner		Immediate Cause (Final disaasa or condition resulting in death)	a	Myocas	dial	info	le	Mon					1 hour
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68	certificate be executed ding physician and tse es the burial-transit	n/Medical	resulting in deeth) Lest										İ	
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Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Yaar Month **Physician** Leslie Ellis Fishell November 3 1999 1228 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Hours Months 10XM 20 F Yrs. 213-24-4933 73 **Director** Nov. 2,1926 Maryland Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow | the Medical Examiner must be notified at MD 1 ☐ Yes 2 X No Director Caroline Federalsburg 284-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 26176 Auction Road "natural", or items 23s 21632 States United deeth Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 Xes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours effer 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver 11th Trucking 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Department of Heelth and Mental Important: If Nem 27 is marked or any injury or other traumatic ave pace. Warren Fishell Mary Lehman Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 26176 Auction RD, Federalsburg, MD 21 lace of Disposition (Name of Date 20c. Location - City or Town, State Doris C. Fishell/ Wife 21632 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Crest Cemetery 11-6 Federalsburg, MD 21. Signature of Funeral Service Licansae 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Home Coale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner physicien end the burial-trensit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated evants resulting in death) Last Dua to (or as a consequence of): Physician/Medical The lew requires that the deeth certificate the Dua to (or as a consequenca of) 50 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No signed b Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 2 No 1 Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1☐ Yes 2☑ No Certification: To 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Division of Vital
To the Hospital or Atlanding Physician: The Within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa

Leslie Fishel Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

State Registrar

edicai

29a. Certifier

(Check only one)

29b. Signature and title of certifian

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Registra

**DHMH 16 Rev 6/95** 

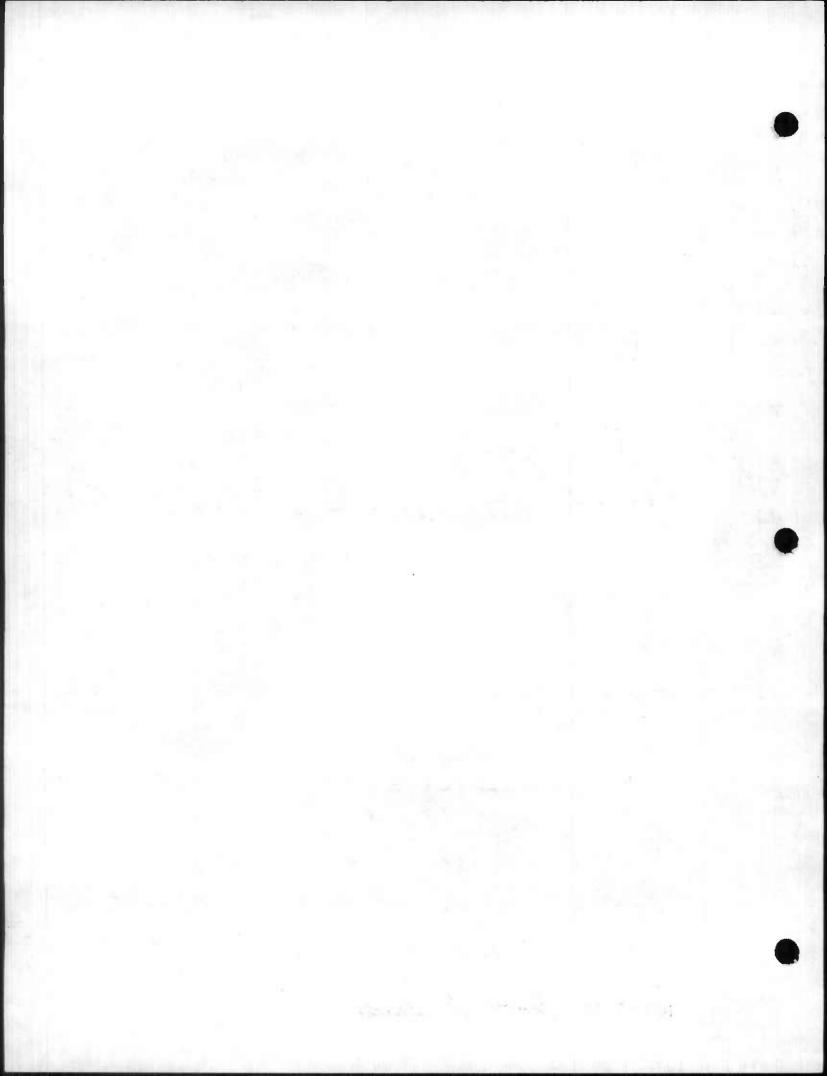
**ORIGINAL** 

🕊 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygienen

**Funeral** Director than "natural", or items 23e or the Medical Examiner must be 72 hours after death Baltimore, Maryland 21215-0020 Hygiene. Pages 1 and 2 should be filed within sent of Health and Mental Hygiene. If of Health a If them 27 is or other trax

> the buriel-transi P.O. Box 68760, physician ate hes been signed by the attending p page 2 should be deteched for use es Division of Vital Records, this certificate funeral director, Aftert the

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Death 3. Time of Death **Physician** Month HELEN DOROTHY **GEORGE** 5 1999 10:00 a.m. November /Medical 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester If Undar 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplece (Stete or Foreign Country) 10M 25 Months Deys Yrs. 212-09-7220 86 Apr. 6,1913 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester 1 Yes 2 No Director East New Market 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3317 Woodland Acres Rd. 21631 U.S.A. by Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes — 22 No If Yes, Give Year or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck. Whita, atc. 1 Never Married 2 Married 1 Yes 7 No Specify → Widowed 4 Divorced white Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 homemaker own home 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumema) Be Frederick Himmelhaber 2 Catherine (unknown) 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Robert Hofmeier - nephew 911 Walker St., Aberdeen, MD 21001 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cramation 3 Removel from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) East New Market Cemetery 11-9-99 East New Market Md. 22. Name and Address of Facility Thomas Funeral Home PA of Funeral Service Licensee 700 Locust St. Cambridge MD 21613 23a. Part. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest sequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 □ Yes 2 No 3 Probably 4 Unknown by Completed 24a. Wes an eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? 2 0 No 21 No 1 Tyes 1 TYes Be 25. Wes case referred to medical exeminar? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA 27. Menner of Death Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 1 ☑ Naturel 2 ☐ Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) or person who completed cause of death (Item 23a) (Type, Print) ambridge mo 21613 Nauky 360 M 360 Aproca 31. Dete filed (Month, Dey, Year) State NOV 0 9 1999 Registrar



	State o	f Maryland / De	epartment of I Dertificate of	Health and M Death		giene 9 9 Reg. No.	3	6308
Physician	Decedent's Name (First, Middle, Last)				2. Dete of De Month	Dev	Yeer	3. Time of Deeth
hysiçian /Medical	ESTHER LEE HAM				Oct.		999	8:50 PM
miner	4e Fecility Neme (If not institution, give street end num			4b. City, Town, or Lo				
eral	Harford Memorial Ho 5. Social Security Number 6. Sex	Spital 7. Age (In yrs. lest birtho	day) If Under 1 Year		8. Date of Bir		ford 9. Birthpl	ece (Stete or Foreign lry) <b>na</b>
or	223-30-8001	75 Yr	s. Months Deys	Hours Min.	6/27/			h Caroli
	10a. State 10b. County	10c. City, Town	or Location				10	Od. Inside City Limits
ctor	MD Harford	Fore	st Hill					1 ☐ Yes 2 <b>17 1</b> 10
Director	10e. Street end Number		10f. Zip Code	0.5.0		10g. Citizen of \	Whet Coun	try?
Funeral	3124 South Ward R			050 Hispanic Origin? (So	ecify Yes or No	USA 14. Bac	a - America	an Indien.
à	Armed Fo	XXNo /e	13. Was Decadent of It Yes, specify Cut  1 ☐ Yes 2 ▼ ★		Rican, etc.)	Bled	white, e	etc.
Completed	15. Decedent's Education (Specify only highest grade completed)	16e. D	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of work	ing	16b. Kind of B	usiness/Ind	lustry
Ē	Elementary/Secondary (0-12) College (	1-4or 5+)		ed)				
	12 17. Fether's Name (First, Middle, Last)	Н	omemaker	18. Mother's Nem	e (First, Middle	, Maiden Sumen	16)	
900	William W. Blackb	urn		Cora P	lummer			
_	19a. Informent's Name/Reletionship (Type, Print)		Mailing Address (Stree				Stete, Zip	Code)
	Patsy Ham- daughter		Box 115	, Forest				- 01-11-
	20a. Method of Disposition  1  ↑  Puriel 2 □ Cremetion 3 □ Removel trom	cemetery,	Disposition (Name of cremetory or other plants		Dete	20c. Location	ansi	
	4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Licensee	wyatt	Family 22. Name end Addr		10/3		I.C.	
	111 11	0:1-	Harkins	•	, Delt	a, PA	1731	4
ledical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Due to (or es e co	nsequenca ot):					
Physician/Med	d							
	Pert II. Other eignificent conditions contributing to de - Rev & C FAILURE	eath but not resulting in t	he underlying cause g	OMY				the ceuse of death?
	-ELECTROLYTH IMB	HAVEL	-AUGMI	4	24e. Wes	an autopsy ormed?	eve	ere eutopsy findings eilable prior to mpletion of cause deeth?
Completed	-CHY				10	Yes 20 No	10	Yes 20 No
Be	25. Was case referred to medical exeminer?	4		26. Plece of Dee	th (Check only	one)		
Certification: To	TLI Yes 2124NO	npatient 2 ER/Outp of Injury th, Day Year) 28b. Tir Inj	ne of 28c. Injury	4 LI Nursing H		idenca 6 Oth		y)
	3 ☐ Suicide 6 ☐ Could not be	of Injury - At home, farming, etc. (Specify)	n, street, factory, office	3		(Street end Numi wn, Stete)	ber or Rura	l Route Number,
edical (	29e. Certifier (Check only one) Certifying Physician: To the bone)	best of my knowledge, asis of examinetion end/ ner stated.	death occurred et the to investigation, in my	time, date end plece, opinion, death occur	, end due to the rred et the time,	ceuse(s) end m date and plece,	enner es si end due to	tated. the ceuse(s)
M	29b. Signeture end title ot cartitier		29c. Licer	nse number		29d. Date signe	ed (Month,	Dey, Yeer)
	7. Parte	MO	11:	12800		10/2	7/40	7
	30. Name end eddress of person who completed caus	se ot deeth (Item 23e) (T	ype, Print)	11	7	1	111	
	31. Dete filed (Month, Day, Year) 32 F	tegistrer's Signature	HUO	my a	10/8			
State gistrar	NOV 0 4 1999	Market of Signature 4	land	,				

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99-6815-013 DDG Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. JAMES R. HOOD JAMES R. HOOD

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MED 13-99 WR.

Reg. No. 9 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** James Robert Hood NOVEMBER 14, 1999 /Medical 4a Facility Nama (II not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2004 BENNETT ROAD **ELDERSBURG** CARROLL If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 25, 1960 Birthplace (State or Foreign Country)
 Maryland 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□ F 38 219-80-7637 Yrs. Director Usual Rasidance of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits show MD Carroll Sykesville Directo or 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6508 Sykesville Road 21784 23a Funeral flame 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indien, Black, Whita, etc. 11. Marital Status hours after 1 ☐ Yas 2X No If Yas, Giva 1 Nevar Married 2 Married 6 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White ď 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Hygiena. Elementery/Secondery (0-12) 12 College (1-4or 5+) Landscaper Landscaping Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) å of Health and Mental Item 27 is marked o Lyman N. Hood Dorothy R. Day 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Mrs. Cynthia L. Hood (Wife) 6508 Sykesville Road, Sykesville, MD 21784 20b. Place of Disposition (Nema of 20a. Mathod of Disposition 20c. Location - City or Town, Stata comatary, crematory or other place)
Lake View Memorial Park 11/20/99 Sykesville, MD N Burial 2 □ Cremation 3 □ Ramoval from Stata Department of Important: If any injury or price. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 1an 0 Haigh. Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause of each line. **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) CONTACT SHOTGUN WOUND OF HEAD Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760, physician use as the Dua to (or as a consequence of):

Completed by Physician/Medical director Be Certification: To funeral the filled in by

27. Mannar of Death

1 Natural

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death.

To the Hospital or Attendi within 24 hours after death To the Funeral Director: A

completely

P.0.

of Vital Records,

Division Attending Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? NO Yes 2 No 25. Was casa ratarred to medical exeminar? 26. Placa of Death (Check only one) XXYas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 KNOther (Specify) SCENE

5 Pending invastigation SELF INFLICTED WOUND 2 Accident 3 Suicida 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be datarminad 28f. Location (Street and Number of Rural Route Number, City or Town, State) 2004 BENNETT RD 4 Homicida ELDERSBURG, FOUND: GARAGE 29a. Cartifia 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2 X Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one)

P 28c. Injury at Work?

28b. Tima of Injury Found: M

29b. Signature and title of certifier

29c. License number

1 Yes 2 No

O.C.M.E.

29d. Data signed (Month, Day, Year) NOVEMBER 15, 1999

28d. Describe how injury occurred

15:55 PM.

1 ☐ Yes 2 No

Approximata Interval Betw Onset and Death

24b. Were autopsy findings available prior to completion of ceuse of death?

1 ☐ Yes 2 ☐ No

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

Usryo B. KORELL Up 111 Penn Street, Baltimore, Maryland 21201 200 31. Data filed (Month, Day, Year)

State Registrar

edicai

NOV 1 6 1999

32. Registrar's Signature

28a. Dete of Injury
(Month, Dey Year)
Found:

30V 187399 James & Speech

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month RUTH CARTER HOLLAND 11 1625 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 10 M 20 F 82 Yrs 216-40-3774 Director 7/7/17 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at TX Yes 2 No Director MD Worcester Berlin 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 300 S. Main St. 21811 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural, or Nan any injury or other traumatic event, the Hedgel Eastmine Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Librarian Public Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Theodore Nelson Carter Mary Stephen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Holland/ Daughter 300 S. Main St. Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate Communication 3 Removal from State **Evergreen Cemetery** 11/11/99 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Europe Service Licensee 108 William St. Berlin, MD o, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Cardionyppnh Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical P.O. 23b. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown B Records, þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA Sign of 27. Manner of Death 1 (SMatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affec 5 Pending investiga or Attending 1 ☐ Yes 2 ☐ No n 24 hours after death we Funeral Director: A plettely fitted in by the f 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, tactory, office building, etc. (Specify) Medical Explicion: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Explicion: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many materials. Medical Within 2 To the F 29b. Signature and title of certi 29c. License number 29d. Data signed (Month, Day, Year) eted cause of death (Item 23g) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

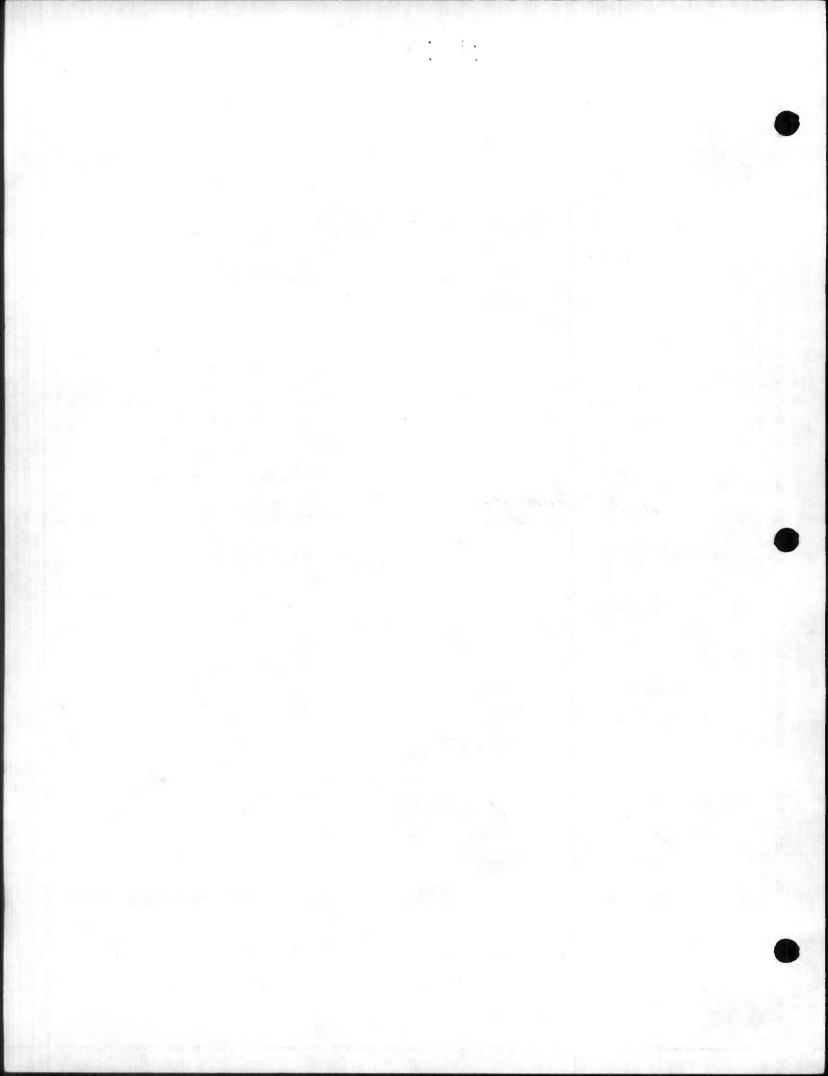
31. Date filed (Month, Day, Year)

NOV

10

1999

32 Registrar's Signatura



	_			1-22-99 J.A.		Cen	tificate o	of Death			Reg. No. 9	0001	
Physician	_	Decedent's Nar	me (First, Middle, L	.ast)						2. Dete of Dea Month	Day	Year 3. Time (	
/Medica			Lynn Hale	eive street end number)	1	-		4b. City. To		Novemb ation of Death			24
Examine	r			emorial Ho		al		Cumberland			,	egany	
Funeral Director	2	5. Social Security 215-48-80 Usual Residence	Number 6.		-	last birthday) Yrs.	If Under 1 Your Months De	ear If Under	24 Hrs. 8	B. Dete of Birt (Month, Day	h y, Year)	9. Birthplace (State Country) Maryland	or Fo
show stat	_	10a. State	10b. County		10c. City, Town or Location						10d. Inside (	City Li	
or 28a-f sho	200	MD	Allegar	ny	Cumberland							X□ Yes	2
or 28		10a. Street and No	umber				10f. Zip Coo	de			10g. Citizen of V	Whet Country?	
23	8		berland S		21502						United		
tural; or items 23s or 28s-1s al Examiner must be notified ed by Funeral Director		44	rried 2 Merried	Armed Forces?	1 ☐ Yes 2☐ No If Yes, Give 1 ☐ Yes 2 ☐			odent of Hispanic Origin? (Specify Yes or No scify Cuben, Mexican, Puerto Rican, etc.) 2 (TNO Specify:			5- 14. Race - American Indien, Biack, White, etc.  Specify: White		
feolical J	The Medical S	(Spe	15. Decedent's lecify only highest groundary (0-12)	rade completed)	completed) (Give kind of work life. DO NOT use			rk done during most of working			16b. Kind of Br	usiness/Industry	
S T		12	(First, Middle, Las	5+		Accou	nting	40.44-4-	d- N1 /	E Add	Accoun		
and Menter ryglene, is marked other that sumatic avant, training.		John Is	Sac Hale Neme/Relationship		ne Print) 19b Meiling Address /			18. Mother's Name (First, Middle Frances McGee Street and Number or Rural Route Num			ee		
											id 21502		
item 27	2		Helen Jean Hale / sist ■. Method of Disposition 1 ☑ Buriel 2 □ Cremetion 3 □ Removal fr			20b. Place of Disposition (Name						City or Town, Stete	
			Cremetion 3		Terrioval from State						O9 Cumberland, MD		
Important: I any injury o pnce.		21. Signature of Funerel Service Licen.  22. Neme end Address of Fecility  Merritt-Adams Funeral Home, P.A.											
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ysician ledical aminer		23a. Pert1. Enter shock, or he Immediete Cause disease or conditi resulting In death)	ert teilure. List onf	mptications that cause y one ceuse on eech li a	ne. DI		r the mode of	tur St. dying, such as	Cun cardiac or	nberlar respiretory er ATED BY		Approxime tnterval Be Onset end	twee
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DHMH 16 Rev 6/95

NOV : 0 900 Seneral 50 March

1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month **Physician** 1999 Irene Elizabeth Hoover November 4 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner FRANKlin Square Hospital Rosedale If Under 24 Hrs. 8. Date BAITIMORE Center If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days 1□M 2 F Hours 212-24-1050 Director 12/23/1925 Maryland Usual Residence of Decedent a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Examiner must b 1 Brett Ct. Baltimore, MD 21221 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes: 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White þ 3 Widowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) 12 Housekeeper Home altimore, Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Peges 1 and 2 should be nent of Health end Mental Lester L. O'Neal Angela Ann Greise 19e. Informent's Name/Reletionship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Item 27 leany Injury or other tra Joseph R. Hoover / son 15333 Brice Hollow Rd. Cumberland, MD 21502 20b. Ptece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method ol Disposition Date 20c. Location - City or Town, Stete Department of 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stata SS Peter & Paul Cemetery 11/8/99 Cumberland, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funarat Sarvice Licensae 22. Neme and Address of Facility Merritt-Adams Funeral Home, P.A. Wale enth 404 Decatur St. d. Cumberland, MD 21502 comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enlar the disease, or comshock, or heart failure. List only **Physician** · Cardiac Arrhythmic /Medical Immedieta Ceusa (Final disease or condition resulting in death)

Examiner

P.O. Box 68760.

Records.

Division of Vital or Attending Physician:

deeth.

To the Hosp within 24 hor To the Fune completaly fi

Physician/Medicai Completed by Be

Medical Certification: To ne Hospital or Attending 24 hours after deeth ne Funeral Director: A pletaly filled in by that

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest 25. Was case referred to medical exeminar? 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 1 ANaturel 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Hypertension 26. Place of Death (Check only one)

Aor

Due to (or es e consequence of)

Due to (or es e consequence of):

Piease Type or Print in Biack Indelibie ink. Assure Ail Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an eutopsy

3. Time of Deeth

10d. Inside City Limits NYes 2 No

Approximate Intervet Between Onset end Death

One Hour

6:03 P.M.

24b. Were eutopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes 2 No

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Yes 2 No

Location (Street end Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year)

Le MD

29c. License number

November 5, 1999

30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print)
Dr Malika Waseem 9000 Fran Klin Square Drive Baltimore, MD 21237 Dr Malika Waseem

Registrar

3

31. Data filed (Month, Dey, Year) NOV 1 0 1999

4 Homicide

(Check only one)

29b. Signeture and title of cartifier

29a. Certifier

32 Registrar's Signatura

from the species

40 1 0 1999

State of Maryland / Department of Health and Mental Hygiene 99 363 | 3

						Ce	rtificat	e of	Death		Re	g. No.			
		1. Decedent's Nama (First, Mid	die, Last)								2. Data of Death	1		3. Tima o	of Death
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) -	Aaiiiiiei	BERLIN NURSING				ON CENT	ER		BEE	RLIN		WOR	CESTER	2	
5		5. Social Security Number	6. Sex			yrs. last birthday)	Y 44 14 4	1 Yaar	If Undar		8. Data of Birth		,		or Foreign
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999	funeral Funeral	11. Marital Status	2. Was Dec	Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (					igin? (Sp	pecify Yas or No-	Race - Amarican Indian,				
hours efter	by Fu	1 Nevar Married 2 Me 3 Widowed 4 Divorce		Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas:			1 ☐ Yas 2 ☑ No Specify:			Hicen, atc.)	Speci	ock, Whita,	ite		
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Menta	To To	Thomas Joseph	Wilm	an					Flo	ren	ce Anders	son			
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of Hear	tho	20a. Mathod of Disposition				b. Place of Dispo	osition (Na	ne of	ne)	1	Data 2	20c. Location	- City or To	wn, Stata	
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permit. Popartm	y Injury	21. Signature of Funeral Service	e Licensee		m	01051 2	2. Nama ar	d Addre	ss of Facili	ty H	ome Profe	egion	al Acc	cocia	tion
288	2 8	21. Signature of Juneral Service Licensee  M0/05/ Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804												LIOII	
	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.  Approximate interval Batwaen											ata		
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To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After	completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	29a. Certifiar 1 X Certify (Check only 2 Medica one)	i Examine	r: On the b	asis of axam	ination and/or in	vastigation	, in my o	pinion, dea	ith occur	, and dua to tha ca rred at tha tima, da	ita and place	, and dua to	tha cause	(5)
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month KATHLEEN G. JOHNSTON 4:45 PM NOV 3 1999 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GILCREST HOSPICE CENTER BALTIMORE BALTIMORE If Under 1 Year 8. Dete of Birth (Month, Day, Year) JULY 12,1917 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. Birthplace (State or Foreign Country) Days Months Hours 1 M 2 F 82 219-03-9510 MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3403 ACTON ROAD 21234 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 2 ☐ No If Yes, Giva 1 Nevar Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Yaar or Datas: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) LUTHER GROSH B. PAULINE GARDNER 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARY JO LAND/DAUGHTER 3403 ACTON ROAD, BALTIMORE, MD 21234 20b. Placa of Disposition (Name of cemetery, cremetory or other place) NOV 6, 1999 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete HILLCREST MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) CUMBERLAND, MD Signature of Funerel Service Licensee 22. Name and Address of Facility HAFER FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 502 Approximate Interval Between Onset end Death RENAL FAILURE Immediate Cause (Final 3 MONTHS diseasa or condition resulting in death) Due to (or es a consequence of): ATHERO EMBOLISM Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): ATHERO SCLEROTIC PERIPHERAL VASCULAR 30 YBARY Due to (or es e consequence of): DISTEASE PERLIPIPEMIA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to CANGESTIVE CARDINE FAILURE 24a. Was en autopsy parformed? completion of cause of death? 1 Yas 2 TNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify + OSPICE 1 Yas 2 XNo 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation

1 ☐ Yes 2 ☐ No

D51228

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) end menner stated.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Box 68760, Physician/Medicai P.O. Division of Vital Records, Completed by or Attending Physician: Be Certification: To

**Physician** 

/Medical

Examiner

Directo

Funeral

Be

Funeral

Director

Maryland 21215-0020

altimore,

Bhuston

1 and 2 should be Health and Mental

**Physician** 

/Medical

Examiner

after death. • Funeral C Hospital Medical

within 24 ho To the Fune completely fi ş non 12

Registrar

**DHMH 16 Rev 6/95** 

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signeture end title by partitier

RAMAN A GOPALAN MD 31. Dete filed (Month, Day, Year)

6 Could not be determined

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

Rhotacan Mb

REAST 32. Registrar's Signature

28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify)

ROLLING (ROPSROADS #159 BALTIMORE

NOV 0 9 1999

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month 26, 1999 1:00 AM Anna Clementine Jones October 0 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 603 Caroline Apartments Denton Caroline If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, May 21, 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 ☐ M 2 💢 F Yrs Director 202-18-8891 88 Pennsylvania Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Heelth and Mental Hygiena. Important: if them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examinar must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Caroline Denton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21629 Funeral 603 Caroline Apartments United States 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: g Specify: Caucasian 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Cashier/Manager Antique Store 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) William Cohee Willard Clementine Mabel Fountain 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 533 Marilyn Drive, East Tawas, Michigan 48730 Daughter Harriet L. Losey 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/29/99 near Denton, Maryland Concord Cemetery 22. Name end Address of Fecility Moore Funeral Home, P.A. 1000 12 South Second Street, Denton, Maryland 21629 23e. Pert<sup>1</sup>. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one cause on eech line. Approximate Intervel Between **Physician** RDIÓVASCULAR /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Due to (or es e consequence of). Examiner ettending physician end for use es the burial-transit law requires that the death cartificete be asscuted Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 ☐ Yes ģ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peed pege 2 s certificate 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury et Work? Certification: 1 Natural 5 Pending s efter death. 2 Accident 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 6 24 hours e 29a. Certifier Medical 1 Certifying Phyefclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted. completaly 2 Medical Examiner: On the basis of examinetion end/or Investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) To the I 29b Significing 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Christian E. Jensen, M.D., PO Box 690, Denton, Maryland

Bener G. Spark

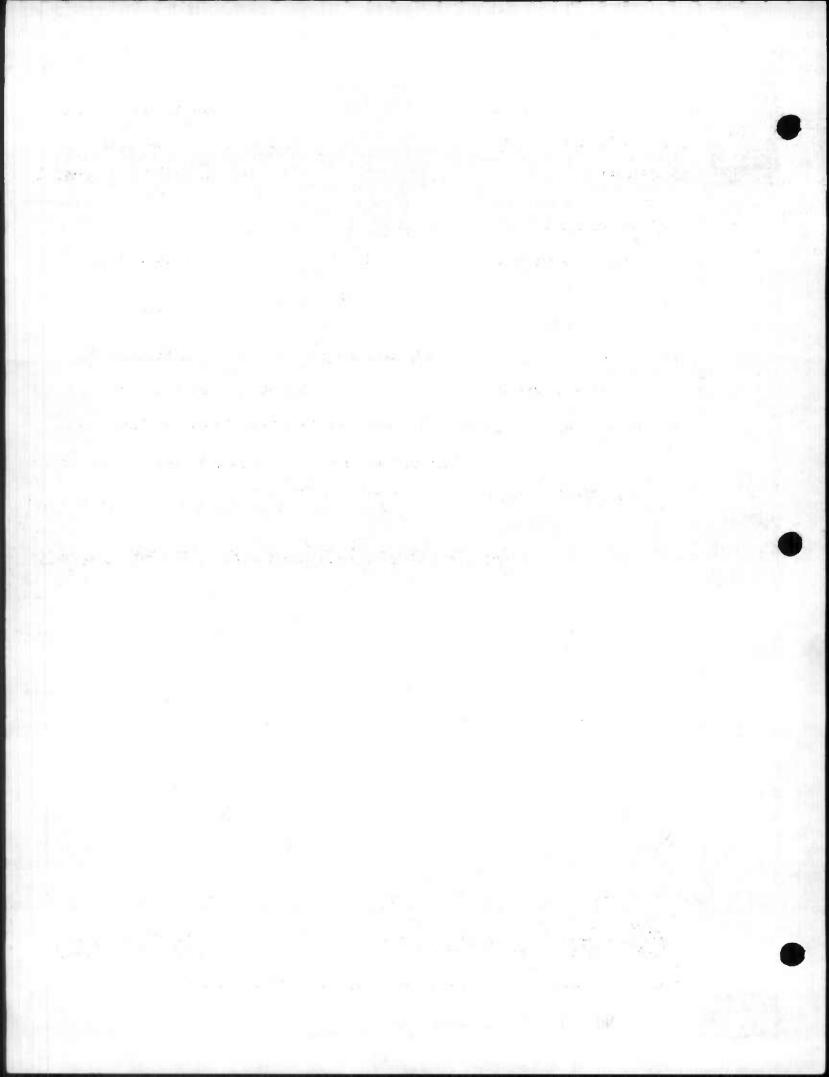
32. Registrer's Signeture

21629

Registrar **DHMH 16 Rev 6/95** 

State

31. Dete filed (Month, Day, Year)



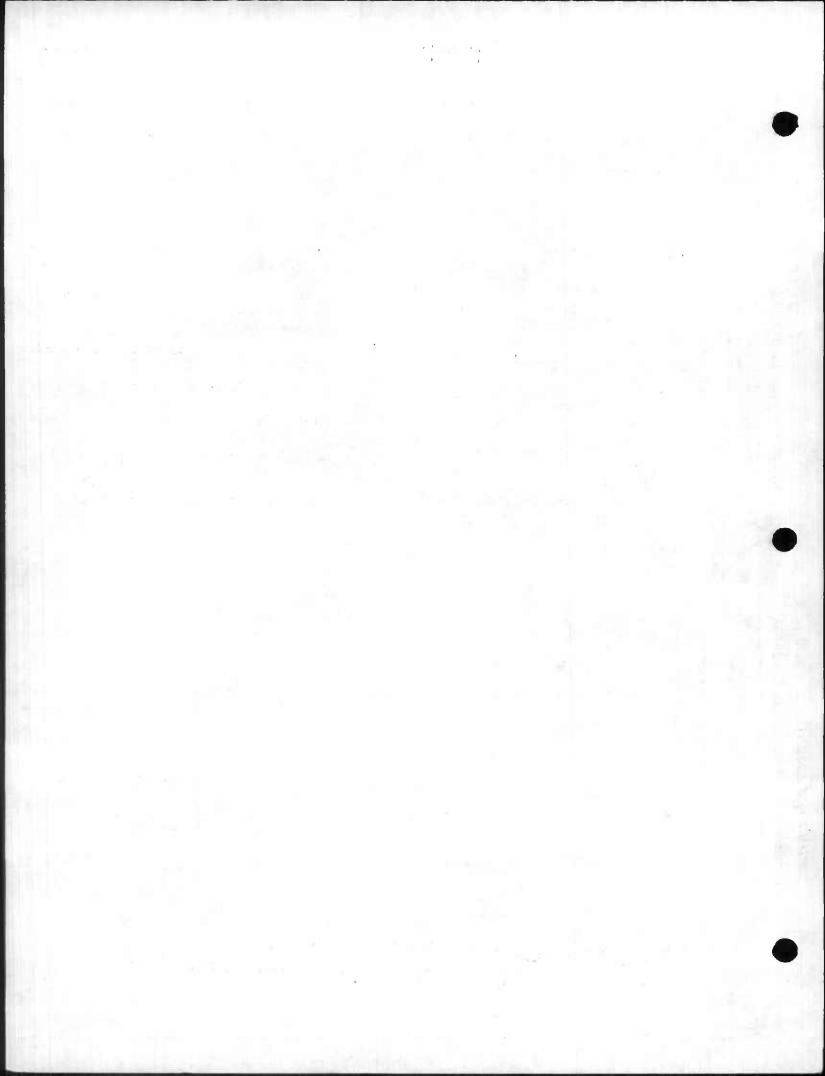
mnmr State of Maryland / Department of Health and Mental Hygiene 99 Edward Kita Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 4:20 p.m. Edward 4b. City, Town, or Location of Deeth 29, 1999 4c. County of Deeth Kita /Medical 4a Facility Name (If not institution, give street and number) Examiner Allegany Memorial Hospital Cumberland If Under 1 Year | If Under 24 Hrs. 6. Sex 1∑ M 2□ F 8. Date of Birth (Month, Day, Year) 12/18/1942 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 186-32-9580 56 Director Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1X Yes 2 No Director Pa. King of Prussia Montgomery 10e Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 363 East Valley Forge Road 19406 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien, Black, White, etc. 72 hours efter 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Dependent of Health and Mentel Hyglens important: if item 27 ie marked other tha any injury or other traumatic event, that baca. Bell Atlantic Phone Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 Edward F. Kita Justinia B. Bodnarsky 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet T. Kita/Wife 363 E. Valley Forge Road King of Prussia, Pa. 19406 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☑ Removel from State 11/3/1999 Upper Merion Twp., PA. St. Augustine Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility J.N. Zumbrun Funeral Home at Funeral Service Licenses monum 6028 Sykesville Road Eldersburg, MD. 21784 to implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner physician and the burief-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) 987 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to Completed completion of cause of death? 2 No To the Hospital or Atlanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOXYes 2□ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred salye of motory that stunch by which 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Certification: 28c. Injury at Work? 1 Natural vehicle 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 3 6 Could not be 28f. Location (Street and Number of Flyal City or Town, State) Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide of oromanin in Alle roodwa edical Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier O.C.M.E. November 1, 1999 cotore se o death (Nem 23a) (Type, Print) 30. Name and address of person who complet THEODORE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Fingintrar's Signature State

NOV 0 2 1999

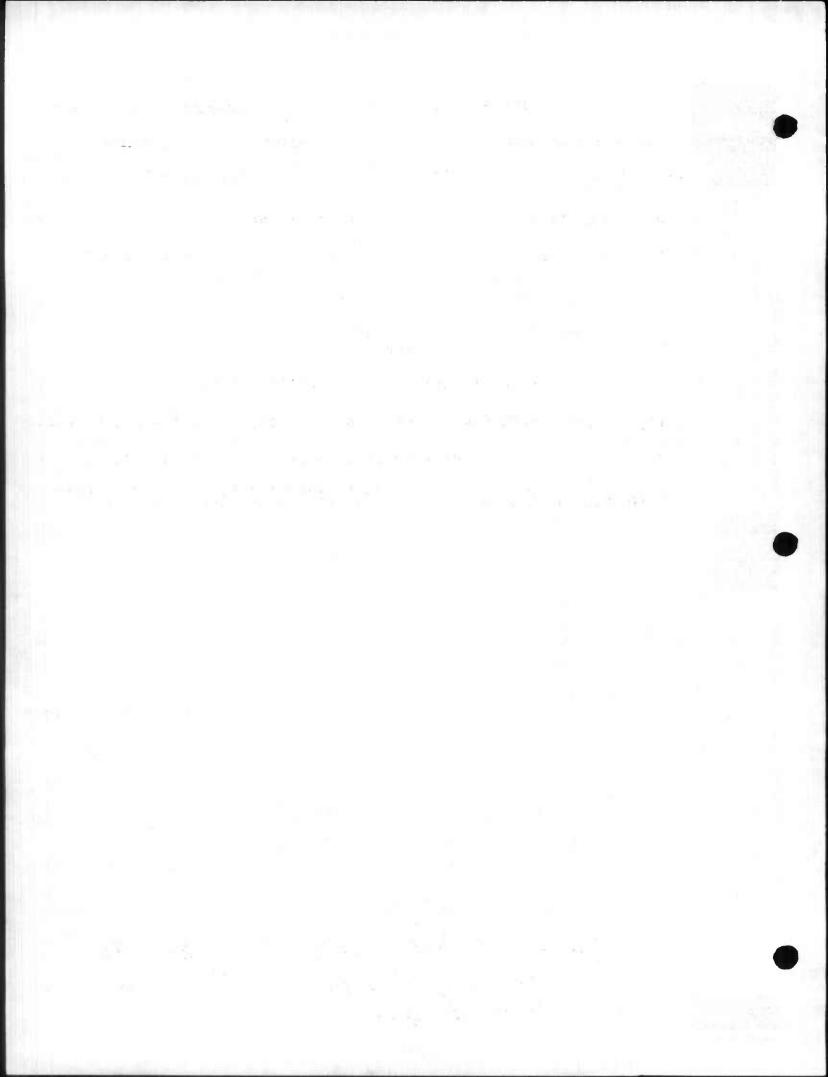
State of Maryland / Department of Health and Mental Hygiene Q Q

	Certificate of Death	Reg. No.	22 36311								
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Physicia /Medica	narry (t. Nenny	NOUSMBER 3	1999 1852								
Examine	4. Ch. 70 at 46 Ch. Tour and a	Y	ounty of Death WICOMICO								
Funeral Director	5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) 150-28-0896 1 Months Days Hours Min.	8. Dete of Birth (Month, Dey, Year) 12-14-39	9. Birthplece (State or Foreign Country) Phil., Pa.								
P	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits								
he Maryi 8a-f sho	Md. Worcester Snow Hill		1 🔀 Yes 2 🗆 No								
death with the Maryland ms 23a or 28s-f show creast be notified at	100. Street and Number 121 South Drive 21863		n of What Country?								
5 2 3	12.1 SOUTH Drive   21003     13.1 Was Decedent of Hispanic Origin? (Specify: Nat')   13.2 Was Decedent of Hispanic Origin? (Specify: Nat')   13.4 Was Decedent of Hispanic Origin? (Specify: Nat')	Rican, atc.)	Race - American Indien, Black, White, etc. Decity: White								
72 hd 72 hd natur	15. Decedent's Education (Specify only highest grade completed)  Elamantary/Secondary (0-12)  College (1-4or 5+) 5+  16a. Decedent's Usuel Occupation (Give kind of work done during most of working) (Give kind of work done during most of working) (Architect	16b. Kind	of Business/Industry er/operator								
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Hyging after a straight and a straight a str	17. Father's Neme (First, Middla, Last)  18. Mother's Nama	(First, Middla, Maiden Su	imama)								
Vlar Venta Venta rife ev	17. Father's Neme (First, Middla, Last)  Joseph Michael Kenny  Wanda H	Klimesz	(Kenny Lee)								
Mary and 2 sho alth and 1 27 is me r traume	19a. Informent's Neme/Relationship (Type, Print)  Sue E. Kenny (wife)  19b. Mailing Addrass (Street and Number or Rura 121 South Drive, Sno										
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or any lajury or other traumatic event, the Medical Energine.	20a. Method of Disposition  1 XBuriel 2 Cremetion 3 Removel from State  4 Donetion 5 Other (Specify)  20b. Plece of Disposition (Nama of cematary, crematory or other place)  Bates Meth.Cemetry		tion - City or Town, State  OW Hill, Md.								
Balti permit. Departri Importa any Inju	21. Signatury   Funaral Service Licensee   22. Name end Addrass of Fecility		O.O. Box 87								
	Dennis Funeral Home, Snow Hill, Md. 218  23a. Pertl. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.  Approximate										
Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in daeth)  ASCVD										
	resulting in daeth)  Due to (or es e consequence of):										
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Box seth cert for use											
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* # 90		1 □ Yes 2 😿	No 3 Probably 4 Unknown								
Inpect KEN nuty ion of Vital Records, and and Physician. The tew requires to the this certificate has been signs in funeral director, page 2 should be at funeral director, page 2 should be		24a. Wes en eutopsy performed?	24b. Were eutopsy lindings eveilable prior to completion of cause of death?								
I Re law		1 □ Yes 2 🗗	No 1 ☐ Yes 2 No								
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Sang P	27. Menner of Deeth 28a. Dete of Injury 28b. Time of Injury et Work? 28b. Time of Injury Work? 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how injury of	occurred								
DIVIS or Atte or Atte or Atte	2 Cadedant S Could set be	28f. Location (Street end I City or Town, State)	Number or Rurel Routs Number,								
To the Hospital within 24 hours a To the Funeral L completely lited	29a. Certifier  (Check only  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a confidence of the confidence										
etho othe othe	29b. Signeture end Muser commit	29d. Date s	signed (Month, Day, Year)								
- FFE	1. ( human) D.O. DME H50487	u	3   99								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher 106 millard St. #206 Salisbury W	Snyder 21804									
State Registra	NOW OF 1000 Me 11 Mar. M.		3								



State of Maryland / Department of Health and Mental Hygiene 99 363 18

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	Physic		Decedant's Nama (First, Middla, Last		G. K	RIEGER	?		2. Data of De Month NOVEMB	ath Day	Yaar 99	3. Time of Death 9:45AM	
	/Medi		4e. Fecility Nema (If not institution, giva					4b. Citv. Town.	or Location of Death			9:45AM	
7	Exami	ner	CAROLINE NURSING					DENTO			OLINE		
	Funeral Director		5. Social Security Number 218-12-1368  Usual Rasidance of Decedent	x 7. Aga (in )	yrs. last birthd 78 Yrs	Months	1 Year Deys	if Undar 24 H	in. (Month, Da	th y. Year) 8,1921	9. Birthi Coul Mar	placa (Stata or Foreign ntry) 'y ] a n d	
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	h with the 23a or 28a	<b>Funeral Director</b>	10e. Street and Number 619 Liberty Ro	o a d		10f. Zip (		1632		ntry?			
020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hyglena. Important: if item 27 is marked other than "naturet; or items 23a or 28a-f show important: if item 27 is marked other than "haturet; or items 23a or 28a-f show any highly or other traumatic event, the Medical Examinat must be notified at once.	by	11. Marital Status  1 □ Navar Merried 2 ☑ Merried  3 □ Widowed 4 □ Divorcad	Armed Forcas?	as Decedant Evar In U,S. med Forcas?  ⊒Yas 2 □ No Yes, Giva aar or Datas: 1 4 3 - 4 5			lispanic Origin? en, Mexican, Pu Specify:	(Specify Yes or No erto Rican, atc.)	pecify Yes or No- b Rican, atc.)  14. Rac Blee		can Indian, etc. ite	
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Baltimore,	permit. Peges 1 end Department of Health Important: If Item 27 any Injury or other tr once.		20a. Mathod of Disposition  1 X Burial 2 Crametion 3 F  4 Donetion 5 Other (Specify)	Ramoval from Stata	cematary,	sposition (Nam crematory or off rest (	her pla	ca) etery	11/5	Federa		own, Stata	
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			23a. Part1. Entar the disease, or compl shock, or haart failura. List only or	ications thet caused the c na causa on each ilna.	leeth. Do not	anter tha moda	a of dyir	ng, such as card	liac or respiratory a	rrest,		Approximata Intarval Between	
	Physician /Medical Examiner		Immediata Causa (Finai disaasa or condition rasulting in daath)	a. he	Sa	tic	(	71/2	1051	5		Onset and Death	
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68760,	that the deeth certificate be executed of by the attending physician and deteched for use as the burish-transit	Medical E	Sequantially list conditions, if any, leading to immediate causa. Entar Undarfying Cause (Disaasa or injury thet initiated evants resulting in daeth) Lest										
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s, P.O	requires that the deeth certificate be executed seen signed by the attending physician and inouid be deteched for use as the burial-transit	by Physician/			Table 1	a oridariying da	oou gii		1 🗆			bably 4 Unknown	
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	ding h. After fune	ation	27. Manper of Death 1 Natural 5 Panding Invastigation 3 Sulcida 4 Homicida 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury M 28b. Injury at Work? 1 Yas 2 No 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib 28d. Dascrib						28d. Dascribe	now injury occui	rea		
Division	ital or Attendurs efter deat	O	3 Sulcida 4 Homicida 6 Could not be datemined	28a. Place of Injury - A building, etc. (Sp.	t homa, farm, ecify)	streat, factory,	office		28f. Location ( City or To	Street and Numi vn, Stata)	er or Run	al Routa Number,	
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	29a. Certifiar 1 Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exem and manner stated.	knowledga, da inetion and/or	aath occurred a r Invastigation, i	t tha tir in my o	na, data and pie pinion, daath o	ace, and dua to tha courred et the time,	causa(s) and m date end pleca,	annar as s end dua t	rtated. o tha cause(s)	
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			30. Nama and addrass of person who co	emplated cause of death (	Itam 23a) (Ty	pe, Print)	M	10	+ CH	- 7	1	tus	
	C+-	to	31. Data filed (Month, Day, Year)	32. Ragistrar's Si	S 7	ر در	1-1	apple		re	NUC	5N A	
	Sta	ite	NOV - 5 1999	Senera /	1	20. 1.							



State of Maryland / Department of Health and Mental Hygiene 36319 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death NOVEMBER 7, 1999 **Physician** 2:20PM EDNA YOUNG LEGAN /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6976 ARCHIE DENNIS ROAD PARSONSBURG WICOMICO If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year)
MARCH 14,1934
MARYLAND 7. Age (In yrs. last birthdey) 9. Birthpiece (Stete or Foreign **Funeral** 1 □ M 2 X F Yrs. 220-32-2093 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Director LEHIGH OREFIELD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18069 USA 1334 CATHEDRAL LANE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Yes 2 🖾 No þ if Yes, Give Yeer or Detes Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HEALTH CARE LICENSED VOCATIONAL NURSE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be BERKLEY ASHTON YOUNG 2 ELIZABETH BYRD 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If them 27 is any injury or other tra-ELIZABETH SMULLEN/DAUGHTER 1334 CATHEDRAL LANE, ALLENTOWN, PA 18069 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removel from State CAMBRIDGE CREMATORY 11/8/99 CAMBRIDGE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Feneral Service Lice 22. Neme end Address of Fecility
ZELLER FUNERAL HOME, P. O. BOX 3171, .1212 OLD OCEAN CITY ROAD, SALISBURY, MD 21802 inplications that gaussed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete tntervel Between Onset end Deeth ly one cause or **Physician** /Medical tmmediate Ceuse (Finei disease or condition resulting In deeth) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Physician/Medical remic Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 🗆 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Lother (Specify) residence 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture and title of confiller 29c. License number 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Principle 200) (Type, Principle Salisbury, Md. effery therton 31. Dete filed (Month, Day Year) 32. Registrar's Signature

State Registrar

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Division of Vital Records, P.O.

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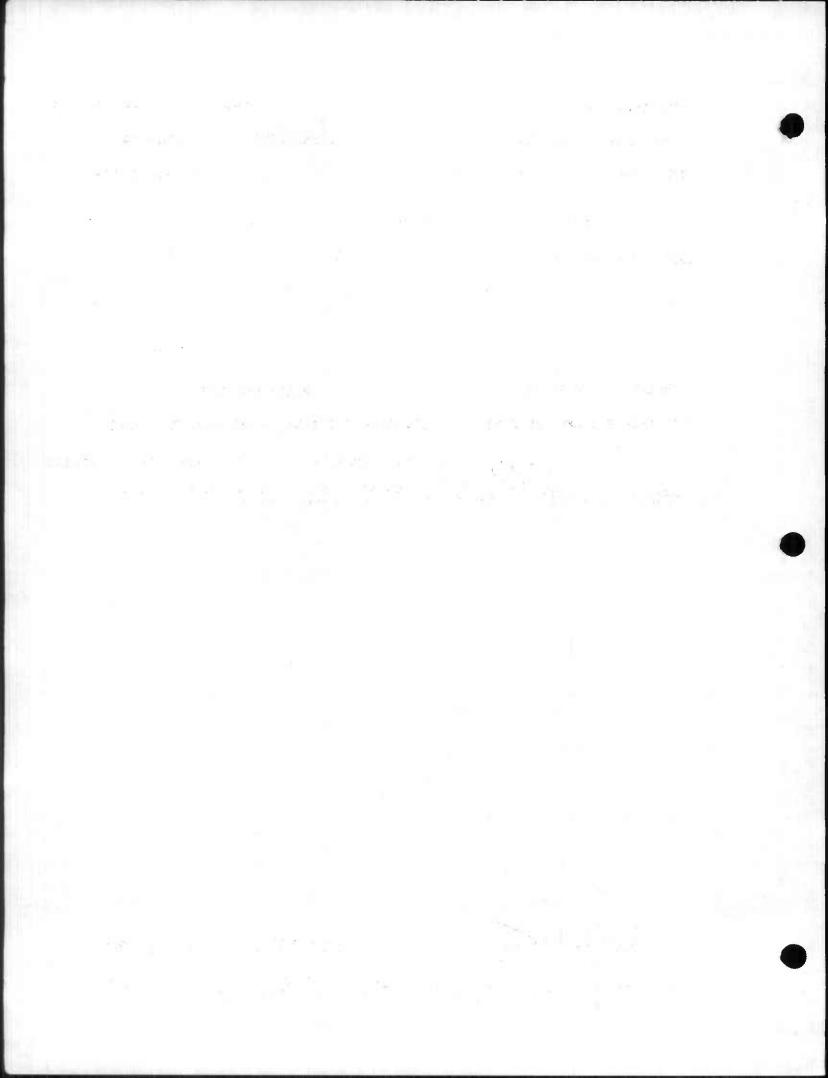
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hours after death with the

Maryland 21215-0020

Baltimore,

the Medical Examiner must be notified at



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth **Physician** Month Year Edna Carolyn Legacy 1999 November 5:30 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Shore Nursing & Rehabilitation Center Denton Caroline If Under 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days 1□ M 2X F Yrs. Director 090-07-0369 Jan 31,1916 New York Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural" or the say fijury or other traumetic events. 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Caroline Henderson 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? Funeral 121 Bee Tree Rd 21640 USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. Yes 2 No f Yes, Give fear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Joseph May Marie Schubert 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert V. Legacy Sr/ husband 121 Bee Tree Rd Henderson, Maryland 21640 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burlel 2 ☐ Cremetion 3 ☐ Ramoval from State Eastern Shore Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Fecility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 23a. Part1. Enter ha disease, or complications thet caused the daath. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or heer feilure. List only one ceuse on each line. Approximete tnterval Between Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: Tha law requires that the death cartificata be assocuted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and compliately filled in by the funeral director, page 2 should be deteched for use as the humal-handle. Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2ŽVIO 3 Probably 4 Unknown Completed by agulopathy 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yas Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2/2 (No Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Sertifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted.
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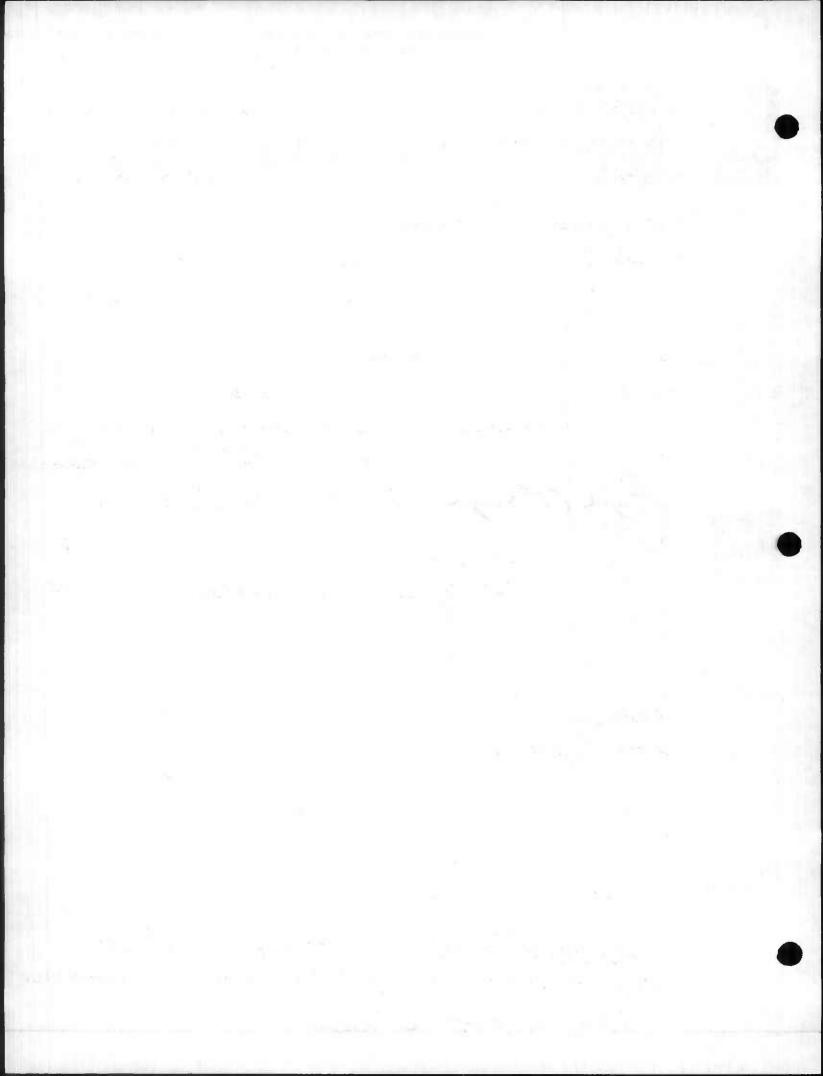
State Registrar

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31. Dete filad (Month, Day, Year)

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G. Sparks



State of Maryland / Department of Health and Mental Hygiene 99 36321

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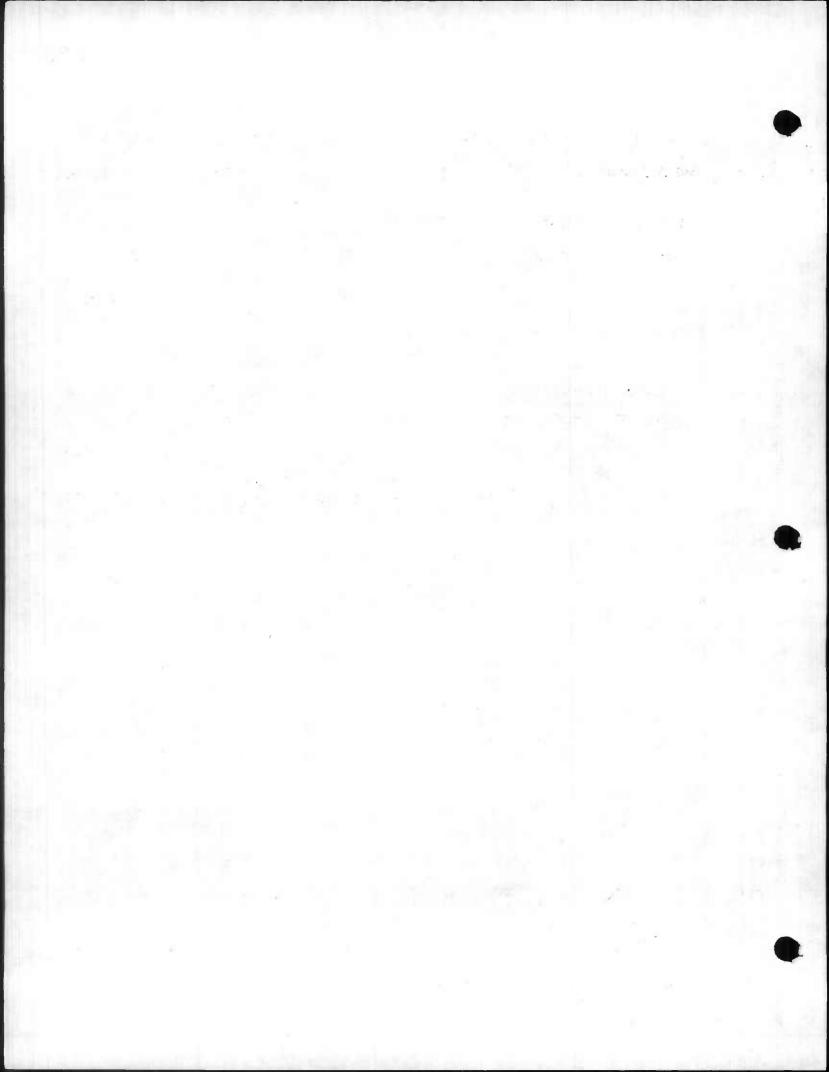
State of Maryland / Department of Health and Mental Hygiene 9 9 36322

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sician edical	Pearl	(n	mn)	Mitzel	_				October		999	7:00 P
miner	4e Fecility Neme (If not institut	tion, giva stre	at end number)				4b. City, To	wn, or Lo	cation of Death	4c. Count	ly of Death	
	3328 Hughes R	Road							ngton		rford	l
	5. Social Sacurity Number 218-32-3539 Usual Rasidence of Decedent		25C) F 7. Age	a (In yrs. last bi	Yrs. If Und Month	lar 1 Yaar s Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 25,	<sup>Year)</sup> 1935	Cou	place (Stata or For htry) Carolina
	10a. Stata 10b. Coun			10c. City, Tow	vn or Location							10d. Insida City Lir
lor	Maryland Har	ford		Darl	ington							1 □ Yas 2 🖾
Funeral Director	10e. Street end Number	LOLG		Duri		Zip Coda			10	g. Citizen of	What Cou	ntry?
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ner	11. Marital Status	12.	Was Decedant E Armed Forcas?	Ever in U,S.	13. Was Dec	cedent of I	Hispanic Ori	gin? (Spe	ecify Yes or No- Rican, atc.)		ce - Amari	can Indian,
by	1 □ Navar Marriad 2 ☑ M 3 □ Widowed 4 □ Divorc	Married	1 Yas 20 N If Yas, Giva Yaar or Dates:	lo		2 34No			rilogii, ato.)	Speci		
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ple	(Specify only high Elementary/Secondery (0-12	-	College (1-4or 5	i+)	(Giva kind of a lifa. DO NOT	use retire	during mos d)	t or work				
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	1 Surial 2 ☐ Crametion 4 ☐ Donation 5 ☐ Other		oval from Stata		ngton C			11	L-4-99 Da	arling	rton,	Maryland
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n	shock, or haart feilura. L	lst only the	usa on aach lin	na.							1	Intervel Between Onsat and Daath
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r	disaasa or condition resulting in death)											
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ial-transit Examiner					consequance		121		7/100014		1 1	/ JEIIIC
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State of Maryland / Department of Health and Mental Hygiene 9 9 36323

			Ce	rtificat	te of	Death	R	eg. No.	30323				
Physician	1. Decedent's Nama (First, Middle, Las	st)					2. Data of Deal Month	Day	3. Time of Death				
/Medical		ARDO					NOVEMBEI						
Examiner	4a Facility Nama (If not institution, give						r Location of Death	4c. County					
	MARINER HEALTH O  5. Social Sacurity Number 6. S		Li vrs. last birthday	If Unde	r 1 Year	FOREST			RFORD				
Funeral Director		□M 257F	91 Yrs.	Months		Hours Mir		Year)	Birthplaca (State or Forei Country)     Massachusetts				
ahow start	10a. Stata 10b. County	10c.	City, Town or L	ocation					10d. Insida City Limit				
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or 22	10e. Street and Number			10f. Zij	p Code		10g. Citizan of What Country?						
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urs after Lumba by Fui	11. Marital Status  1 Nevar Married 2 Married  32 Widowed 4 Divorced	12. Was Decedent Evar i Armed Forces? 1 ☐ Yas 2☒ No If Yas, Giva Year or Datas:	Yas 2⊠ No as, Giva 1 ☐ Yes 2%			ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yas or No- rto Rican, atc.)	No- 14. Race - Amarican Indian, Black, Whita, atc.  Specify: White					
ed within 72 hours at ygiena. wr than "natural", or rt, tha Madical Exam Completed by I	15. Decedent's Ed (Specify only highest gra	lucation 16a Decade		edent's Usual Occupation be kind of work done during most of working DO NOT use retired)			ndina	16b. Kind of B	usinass/Industry				
d within giena.	Elemantary/Secondary (0-12)	Collega (1-4or 5+)	life.	DO NOT	se retired	)	UKEN						
ygiena. ygiena. yer than rt, me t	12		Seci	retar	y / I	300kkeep		Retai					
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d 2 should be filed in and Mental Hygies 7 is marked other traumatic avant, It To Be Co	Antonio Padua		401- 14-11		. (01		sca Alic						
0 0 0 0		19a. Informant's Name/Relationship (Type, Print)  Robert F. Magardo/ Son  1904 Angles											
ges 1 and t of Health if item 27 or other tr	20a. Mathod of Disposition		b. Place of Disp	osition (Na	me of		-		City or Town, Stata				
emit. Pages 1 a Separtment of Her mportant: If item iny injury or othe	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Stata	cemetery, cre	matory or o	otner plac		11-5-99	Towson	, Maryland				
pemit. Pag Department Important: I any injury o	21. Significant of Fugeral Sarvice Licen					-			, rarytara				
Departit Departit Importu any inje	De dolla &	nelaman					lome, P.A.		21000				
	23a. Part I. VEntar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.  Approximate Interval Between												
Examiner	Immediate Causa (Final disease or condition rasulting in death)  a. Cereb l vaculur and X Turk  Due to (or as a consequence of):												
physician and sthe burial-transit	Sequantially list conditions, if any, laading to immadiate cause. Entar Undartying Cause (Diseasa or injury c.												
5 O 6 2	rasulting in death) Last  Dua to (or as a consequence of):												
death d for	Part II. Other significant conditions or	Other significant conditions contributing to death but not resulting in the underlying cause given in							ntribute to the cause of deat				
ires that the death certical signed by the attending to be deteched for use a by Physician/M	alul f	Mulla	L_	and dry mg (				es 2Q No	3 Probably 4 Unkno				
The law require: cate has been sig page 2 should b							24a. Was a perform	n autopsy ned?	24b. Ware autopsy findings available prior to completion of causa of death?				
The law requires the last been signe page 2 should be completed by							1 U Y	s 2 No	1 Tas 2 No				
stclan: The law certificate has birector, page 2 s	25. Was casa rafarred to medical examinar?					26. Place of D	eath (Check only on	e)					
Physician: rhis certific ral director, TO Be (	1 Yas 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie			4 Nursing	Home 5 ☐ Reside	ence 6 🗆 Oth	ear (Specify)				
Attending Phrideath. actor: After the by the funeralification:	27. Manner of Death Natural 5 Pending 2 Accidant invastigation		28b. Time of Injury	of M	28c. Injun Work	yat k? Yas 2 □ No	28d. Describe ho	ow injury occur	red				
tal or Attanding P as Diractor: After led in by the funers Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida determined	28a. Place of Injury - A building, atc. (Sp.		reet, factor	y, office		28f. Location (Si City or Town	reet and Numb n, State)	per or Rural Routa Number,				
n 24 hound no 24 h	29a. Certifiar Certifying Phyone) Concept Certifying Control Certifying Phyone Certifying Certifying Certifying Certifying Phyone Certifyi	ysician: To the best of my liner; On the basis of axam and manner stated.	knowledge, deat ination and/or in	h occurred vestigation	at the tin	na, data and place pinion, death occ	ce, and due to tha courred at the tima, d	ause(s) and ma ata and place,	anner as stated. and dua to tha cause(s)				
To the To the comp	29b. Signatura and titla of certifiar			29	c. License	number	2	9d. Data signe	d (Month, Day, Year)				
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State	31. Data filed (Month, Day, Year)	32. Registrar's Si	gnatura L	1									
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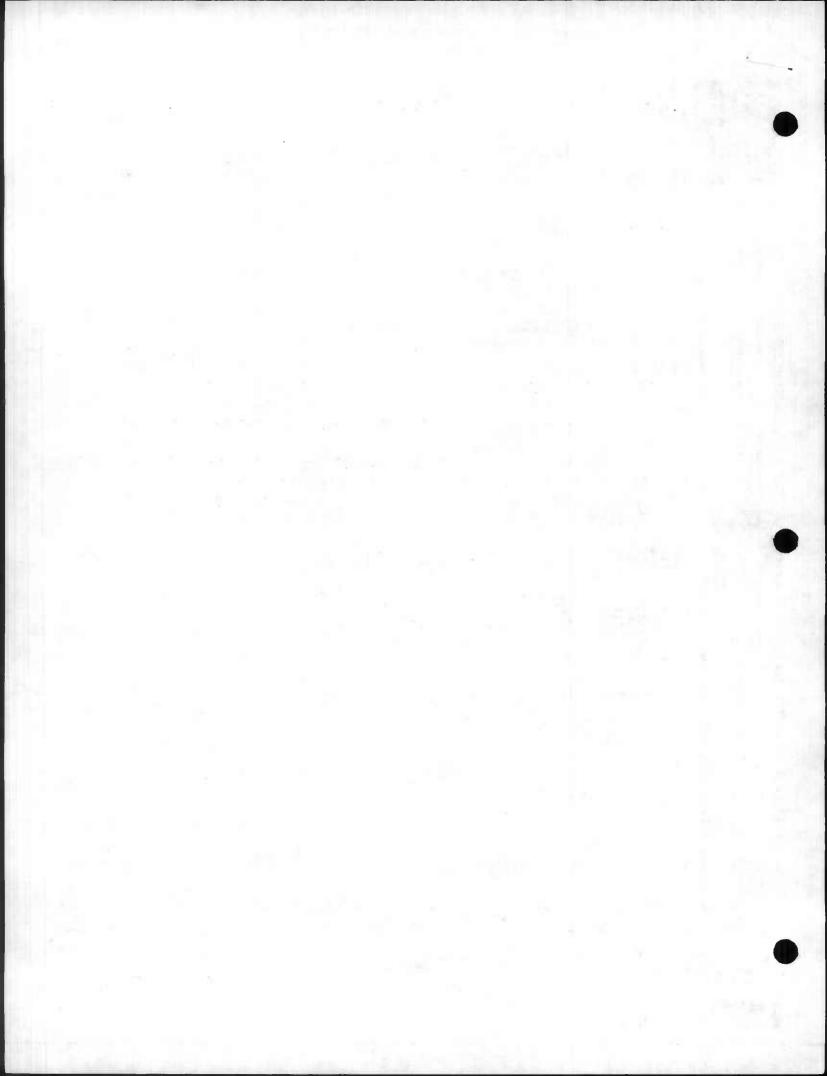


36324 State of Maryland / Department of Health and Mental Hygiene 9 Amend Item# 5 HCHD 11/16/99 Breath 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 04 Nea Illiam lovember om /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Salfimore Mar NSTEMS Ima 101 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 212 - 34 - 2567 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 180 M 2□ F Months Days Hours Min Yrs Director 61 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 CXNo Directo 28a-1 Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be "natural", or Itama 23a 1005 Lees Wood Road 21014 USA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 \$70000 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fled within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Municipal Government 5+ Administrator 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be frount of Health and Mental Health it from 27 is marked of William Neal McFaul, Jr. Grace (nmn) Sumpter 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health ar Important: If Itsm 27 is any injury or other trau 1005 Lees Wood Road, Bel Air, MD 21014 Iris W. McFaul / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 11-13-99 Bel Air, Maryland M Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) BI rentricular Examiner Examiner physician and the buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, onomna 256 certificate be Physician/Medical Due to for as a con 88 for use as 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed D990 has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2NNo Unpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After Hospital or Attending Natural 2 ☐ Accident 5 Pending investigation n 24 hours after death.

The Funeral Director: After Selection of the furnishment of the 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. (Check only one) within 2 the th 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Resident Surgeon 11/8/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 ,14 -, MD Greene 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2



Certificate of Death

To the Hospital or Attending within 24 hours after daath.
To the Funeral Director: Afte completely filled in by the fune

_								00	rimou		Doutin		Heg. No.				
	Physic /Medi		1. Decedent's Nem Martin	oe (First, Middle, L Joseph 1		Sr.						2. Dete of Month Nove	Day	1999	3. Time of Death 4:18pm		
	Exami	ner	4a. Fecility Neme ( Carroll	of not institution, g County (			pital				4b. City, Town Westmi	, or Location of D Inster		nty of Deet	h		
	Funeral Director		5. Social Security N 199–28–4	785 6.	Sex 1XIM 2□ F	7. Age 60	(In yrs. lest	birthdey) Yrs.	If Und Months	er 1 Yee Deys		Min. (Month	f Birth , Dey, Year) 25 1939	9. Birt Co Pa.	hplace (Stete or Foreign untry)		
	70		Usuel Residence o	f Decedent													
	e Marylan	ctor	Md Md	Carrol	l		Woodk		ocation						10d. Inside City Limits 1 ☐ Yes 2 No		
	h with the	al Director	7404 Old	Washing	ton Road	d				ip Code 1797	7		10g. Citizen USA	of Whet Co	untry?		
020	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or frems 23s or 28s-f show ent, the Medical Examine must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 □ Divorced	12. Wes De Armed F 1  Yes If Yes, G Year or	orces? 2X N ive			Was Dec If Yes, sp			? (Specify Yes o Puerto Rican, etc.	) [	Race - Ame Bleck, White acify: Whi			
7	2 ho	8		15. Decedent's I	Education		10	6a. Dece	dent's Us	ual Occu	petion		16b. Kind o	f Business/	Industry		
21215-0020	S E D >	Completed	(Spec	only highest g		(1-4or 5-	+) m∈	(Give life. edica	kind of w DO NOT al SC	ork done use retir ienc	ipetion e during most of ed) Ces lias	working SON		Bb. Kind of Business/Industry Darmaceudicals			
maryland 2		To Be Co	17. Fether's Neme John Mat									Name (First, Michael Mayla	ddle, Meiden Sun th	neme)			
_	h ar	-	19a. Informent's Na Patricia			use)							umber, City or To				
Baltimore,	一工品有		20e. Method of Dis 1 XBurial 2 4 ☐ Donetion	State	20b. Place ceme	e of Dispo		eme of other pla	ece)	Dete	20c. Location	20c. Location - City or Town, Stete Sykesville, Md					
Dail	permit. Pages Department of Important: If it any injury or once.		21. Signeture of Fu	onerai Service Lice		J+							Funeral, Md 217		& Chapel		
	Physician		23a. Pert1. Enter to shock, or hee	he diseese, or cor nt feilure. List only	nplicetions thet y one ceuse on	caused eech line	the deeth. C								Approximate Intervel Between Onset end Death		
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)  e. CORONANT ARTIST DISSAS								5/13 F	12 Y5MA					
		ner	Due to (or es e consequence of);														
Ď,	axecutac an and inal-trans	Examiner	Sequentially list co if eny, leading to in cause. Enter Unde Ceuse (Disease or	nditions, nmediate orlying	b. ———		Due to (or es	e consec	quence of	):							
0x 68/60	e law requiras that the death certificate be axecuted has been signed by the attending physician and ga 2 should be detached for use as the bunat-transit	an/Medical	thet initiated events pue to (or es e consequence of):														
0 0 0			Pert II. Other signif	Icent conditions	contributing to	death but	t not resulting	g in the u	nderlying	cause g	iven in Pert I.	23b.	Did tobacco use	contribute	to the cause of death?		
ŗ.		by Physici	17473	アフラン	SION								1 □ Yes 2 🖼 🕅	o 3 Pr	obably 4 Unknown		
ecords		Completed t						_				246. \	Ves en eutopsy enformed?		Nere eutopsy findings eveileble prior to completion of cause of deeth?		
_	The ate	00											☐ Yes 250	0 1	I ☐ Yes 2 ☐ No		
VII	Physicien: The this certificate ral director, page	Be (	25. Wes case refer examiner?	red to medical							26. Plece of	Deeth (Check o	nly one)				
	5 00		Hospitel: 1 Inpatient 2 KR/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence							Residence 6 🗆	Other (Spec	cify)					
0 00	iding Physith. After this funeral di	ation:	27. Manner of Deets  1 Netural 2 Accident	5 Pending Investigation	28e. Dete (Mor			b. Time o		28c. Inju		28d. Descr	ibe how injury oc				

State Registrar

Medical Certificati

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

NOV 0 3 1999

30. Name end eddress of person wood completed cause of deeth (Item 23e) (Type, Print)

6 Could not be determined

32. Registrer's Signeture

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOW ADDG. LANHAM, MD ZIS WASHINGTON HOT WESTMINSTER MUZIIST

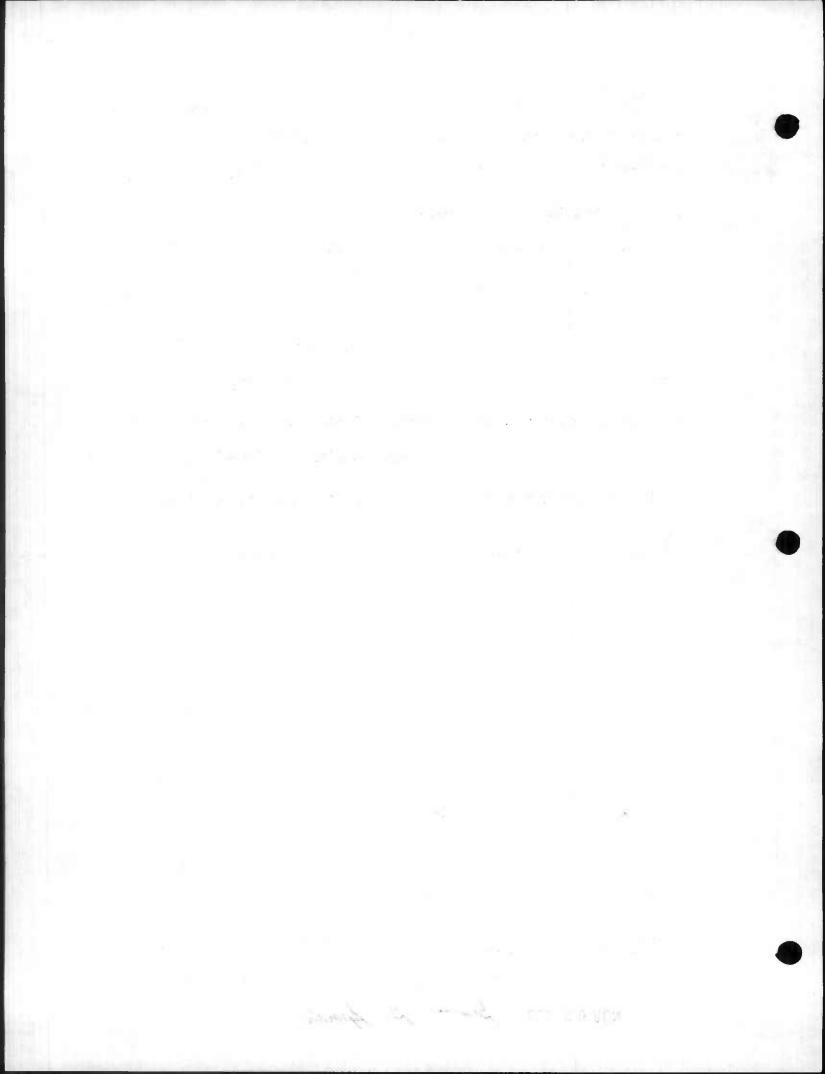
Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

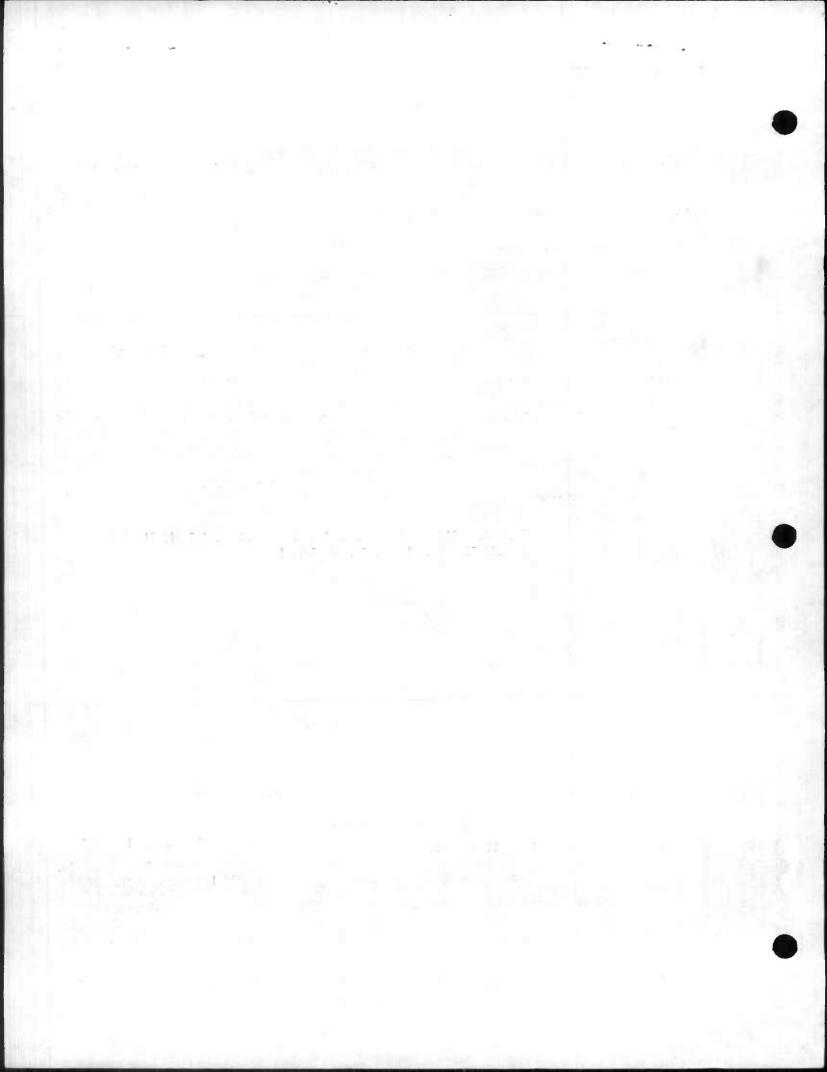
29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)



4. Facility Name (if not institution, pive strong and number)  Dorchester General Hospital  Dorchester General Hospital  1. Do	Time of Death L: 18 PM.		2. Dete of Death Month November		1. Decedent's Name (First, Middle, Last) William John Meekins								
Social Security Number 217-36-1999 YEM 21F 7. App fit yes, East Seriedary 127-36-1999 YEM 21F 61 100. CBy, Town or Location 100. State 100. CBy, Town or Location 100. State 100. CBy, Town or Location 101. Zp Code 21634 US 101. Zp Code 110. Zp Code 110. Zp Code 110. Zp Code 110. Zp Code 110. State and Number 127-36 Hoopers Island Road 111. Marial Status 110. News Married 21 Married 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 121. Was Decederic Ever in U.S. 122. Was Decederic Ever in U.S. 123. Was Decederic Hispanic Origin? (Specify Yes or No- 121. Page 121. No Specify 121. Specify Codes Medical, Justin Was Decederic Ever in U.S. 122. Was Decederic Ever in U.S. 123. Was Decederic Hispanic Origin? (Specify Yes or No- 121. Page 121. No Specify 121. Specify Closes, Medical, Last or Version Every U.S. 122. Was Decederic Ever in U.S. 123. Was Decederic Hispanic Origin? (Specify Yes or No- 124. Page 125. Specify 124. Decederic Ever in U.S. 125. Was Decederic Ever in U.S. 126. Decederic U.S. 126. Decederic U.S. 126. Decederic U.S. 127. Father's Name (First, Medical, Last) Waterman 126. Decederic U.S. 127. Father's Name (First, Medical, Last) Waterman 127. Father's Name (First, Medical, Medical Surname) Waterman 128. Market Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Page 128. Decederic U.S. 129. Decederic U.S. 129. Page 128. Decederic U.S. 129. Decederic U.S. 129. Decederic U.S. 129. Dece		4c. County of Deeth	ocation of Deeth		4		num <i>ber)</i>	ive street and nu	not institution, giv				
Use State   Top Code			_		nder 1 Year	-				5 Social Security Nu			
Top   Country   Top   Countr		38 Country)	Oct 3, 193					NOM 2□ F					
Maryland   Dorchester   Fishing Creek   100, Citizen of Whist Country   100, Street and Number   2716 Hoopers Island Road   107, 2p Code   21634   US   11   Martial Status   100, Wester Martind   12   West Decedent Ever in U.S.   13, Wes Decedent of Hispanic Origin? (Specify Yes on Notice 100, 100, 100, 100, 100, 100, 100, 100	Inside City Limit	10d.				y, Town or Loca	10c. Cit						
2716 Hoopers Island Road   21634   US   Secondary   11   Marka Status   11   Marka Status   12   Mass Deceded Per in U.S.   13   Wes Deceded of Fispanic Origin? (Spacify Yes on Notice of Spacify   15   Deceded of Spacify   15   D	1□ Yes XX No							ster	Dorches	Maryland			
11. Marital Status 10. Mercet Merrid 2 Merred 11. Mercet Status 11. Specified Status 11. Specified Status 11. Specified Status 11. Specified Status 12. West Decodert Ever in U.S. 11. Vest 2 (Mo. Vest, 6 (Mo. Specified Status) 11. Specified Status 12. West Decodert Status (Mo. Specified Status) 13. West Decodert Status (Mo. Specified Status) 14. Rece - American Index Mercet 15. Specified Status (Mo. Specified Status) 15. Specified Status (Mo. Specified Status) 16. Specified Status (Mo. Specified Status) 17. Faither's Name (First, Middle, Last) William Kinnamon Meekins 19. Index mercet Status (Mo. Specified Status) 19. Index mercet Status (Mo. Specified Status) 19. Mailing Address (Street and Number or Pural Route Number, City or Town, Stee, Zp Code 19. Mailing Address (Street and Number or Pural Route Number, City or Town, Stee, Zp Code 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address (Street and Number or Pural Route Number) 19. Mailing Address			10g.	34			d	and Road					
Studiowed   Librorocal   Year or Detect		14. Race - American Bleck, White, etc.	pecify Yes or No- Prican, etc.)	spanic Origin? (Sp n, Mexican, Puerto	ecedent of Hi specify Cubar	117	ecedent Ever in U Forces? s 2 [V] No	12. Was Deco	ed 2 Merried	11. Marital Stafus  1 🕅 Never Merrie			
Commerting Name (First, Middie, Last)			166					Year or D	- Introduce				
18. Mother's Name (First, Middle, Maiden Sumane)   William Kinnamon Meekins   William Kinnamon Meekins   Venia Meekins   Ven	,	b. Ning of ousiless/fiousi	king	furing most of work	f work done d IT use retired,	(Give ki		rade completed)	fy only highest gra	(Specif			
William Kinnamon Meekins  Venia Meekins  19e. Informent's Neme-Relationship (Type, Print)  Teresa M. Tolley Niece  106 Vue de L'eau Street Cambridge, Maryland  20a. Method of Disposition 10 Disposition			na /First Middle Maid	18 Mother's Nem	nan	Wate							
Teresa M. Tolley Niece  20a. Method of Disposition  TOBourial 2 Coremetion 3 Chemovel from Stete    Dob Pisco of Disposition (Name of Commenter) Commenter (Presently or Order) price)   Hosier Churchyard							ins						
20a. Method of Disposition   17(Burdal 2   Cremetion 3   Removel from Stete   4   Donaton 5   Churr (Specify)													
### Application of the place of Death of Specify   Due to (or es a consequence of):    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Perl I.    Part II. Other algnificant conditions contributions to the cause of the contributions to the cause of the cause o				1	(Name of	lece of Disposit	20b. F	Niec					
22. Name end Address of Fecility Thomas Funeral Service Loansee  22. Name end Address of Fecility Thomas Funeral Service Loansee  23. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.  Approximate the cause (Final disease or condition resulting in death)  24. Approximate Cause (Final disease or conditions conditions, if any, leading to immediate Cause (Final disease or condition resulting in death)  25. Quentially list conditions, if any, leading to immediate cause (Final thieled event but that initied event but that initied event but that initied event but that initied event but that initied event but that initied event but that initied event but that initied event but that initied event but that initied event but that initied event but the conditions contributing for death but not resulting in the underlying cause given in Pert I.  25. Wes case referred to medical event but that in the event but the conditions contributing for death but not resulting in the underlying cause given in Pert I.  26. Place of Death (Check only one)  27. Wanner of Death  28. Place of Death (Check only one)  28. Deter of Injury  (Month, Day Year)  (Month, Day Year)  28. Deter of Injury at fining the death of the conditions of the conditions of death or the conditions of the cond				1	1 Burial 2 Cremetion 3 Removel from State								
23a. Public Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shelds, or heart failure. List orly one cause or each fine. Check only one cause or each fine. Check only one cause or each fine. Check only one cause or each fine. Check only one cause or each fine. Check only one cause or each fine. Check only one.  ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND ALCOHOL INTOXICATION Check only one.  ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND ALCOHOL INTOXICATION Check only one.  COMPLICATED BY ENVIRONMENTAL HYPOTHERMIA  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  23b. Did tobacco use contribute to the cause of the contribution of the contribution of the cause of the contribution of the			ne, P.A.	s of Fecility neral Hom	Thomas Funeral H 700 Locust Stree								
24e. Wes an autopsy performed?  24b. Were autovaliable completic of death?  1  Yes 2 No 1 Yes  25. Wes case referred fo medical examiner? 1  Yes 2 No 1 Yes  26. Place of Death (Check only one)  27. Manner of Death 1  Natural S Pending investigation investigation investigation investigation investigation and investigation of the determined investiga					of):	r es a conseque	Due to (c	b	mediate tying njury	if any, leading to imm cause. Enter Underl Cause (Disease or in that initieted events			
24e. Wes an autopsy performed?  24b. Were our evailable completing of deeth?  1  Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	cause of death	acco uae contribute to th	23b. Dld 1obac	en in Pert I.	ng cause give	ulting in the und	death but not res	contributing fo de	cant conditions c	Part II. Other signific			
25. Wes case referred fo medical examiner?  1	y 4⊠Unknon	2 No 3 Probeb	1 Yes										
25. Wes case referred fo medical examiner?  1	autopsy findings ble prior to ation of cause th?	ed? evailal compl											
examiner?  1 X Yes 2 No  1 Infinite to 2 X EP/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 2 ESC. Injury at Work?  2 X X-Cident 3 DOA  1 Natural 2 EXC. Specify  28a. Dete of Injury A M 1 Yes 2 No  1 Natural 2 EXC. Specify  1 Noticide 4 Homicide  28b. Time of Injury A M 1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  EXPOSED TO COLD ENVIRONMENT  28c. Location (Street and Number or Rural Rout City or Town, State) 2716 HOOPERS  FISHING CREK, MARYLAND  29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.	es 2 No	2 No 1 Y	1)∑ Yes										
27. Manner of Death 1 Natural 2 Natural 3 Natural 2 Natural 3 Natural 2 Natural 3 Natural 2 Natural 3 Natural 2 Natural 3 Natural 2 Natural 3 Natural 2 Natu		no 6 DOthor (Specific)		V-	Othe	EB/Outpations	Tennetions 2	Hospital:		examiner?			
2 CACCIDENT INVESTIGATION 3 Suicide 4 Homicide  28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) FOUND: HOUSE  29a. Certifier (Check only)  29a. Certifier (Check only)  29b. Could not be determined  29c. Certifier (Check only)  29c. Certifier (Check only)  29c. Certifier (Check only)  29c. Certifier (Check only)  29c. Certifier (Check only)  29c. Could not be determined  29c. Location (Street and Number or Rurel Rout City or Town, State) 2716 HOOPERS  FISHING CREEK, MARYLAND  29c. Certifier (Check only)  29c. Could not be calculated the number or Rurel Rout (City or Town, State)  27c. Maryl And (Check only)  29c. Certifier (Check only)		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				28b. Time of			1.5	27. Manner of Death			
29a. Certifier  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  (Check only  Check only  Check only  (Check only  Check only  (Check only  Check only  Check only  (Check only  Check only  Check only  Check only  (Check only  Check only  Check only  Check only  (Check only  Check on	ute Number	et end Number or Rurel Ro Stete) 2716 HOOPER		101	11:30 A	11-4-99 ce of Injury - At hi ding, etc. (Specif	FOUND 28e. Place buildi	investigation 6 Could not be	2 (☐)(Accident 3 ☐ Suicide				
		se(s) end menner es stete	end due to the cause				ne best of my kno	hysician: To the					
one) 25 and manner stated.  29b. Signature and title of certifiet 29c. License number 29d. Dafe signed (Month, Dey, Y									71	one)			
O.C.M.E. November 5, 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							l	elfrel	mte on	▶ Mory			



Registrar DHMH 16 Rev 6/95

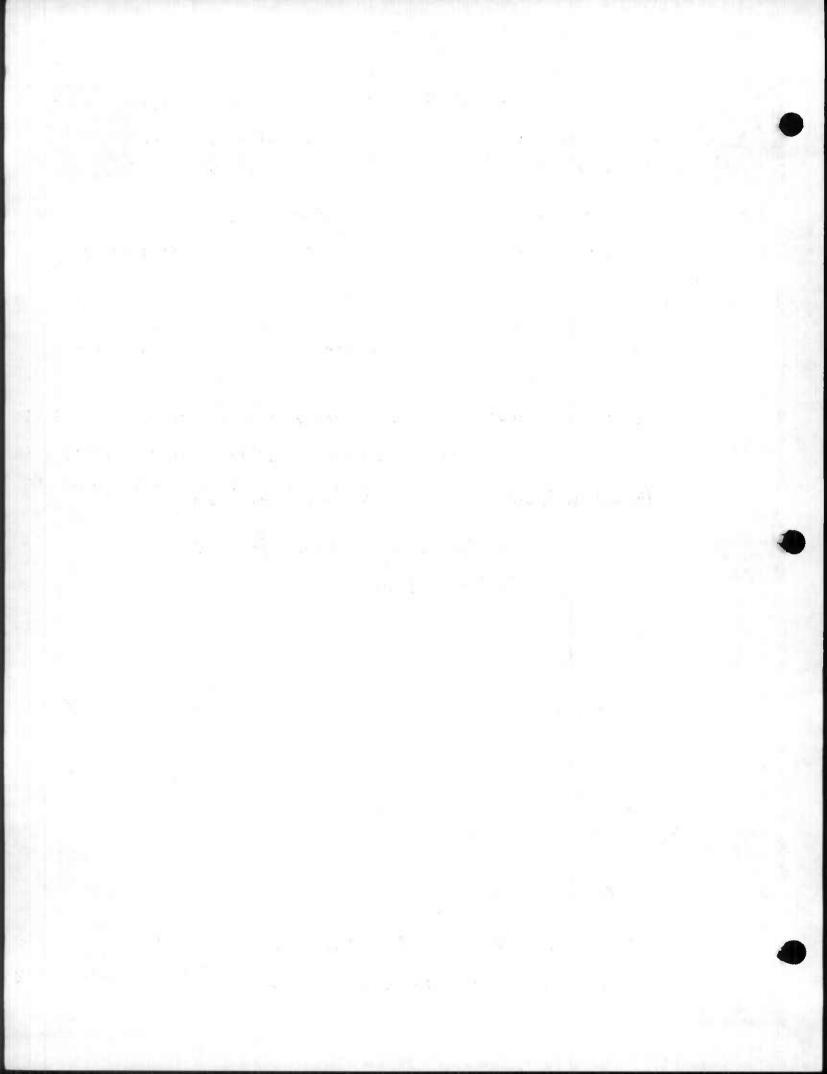
State

NOV 0 9 1999

State of Maryland / Department of Health and Mental Hygiene 99

e 99 3632

					Ce	rtificate of	Death		Reg. No.	2 00050
	Physic /Medi		Decedent's Neme (First, Middle, Lase	L. MILD	RED M	ITCHELL		2. Dete of D Month NOV.		3. Time of Death 2310
P	Exami		4e. Fecility Neme (If not institution, give 6761 Eldorado				Feder	or Location of Dee	Doro	of Deeth Chester
,	Funeral Director		213-12-3330A		89 Yrs.	If Under 1 Year Months Deys	If Under 24 Hours	Hrs. 8. Date of B (Month, D Apr. 2	irth ey, Year) 2,1910	9. Birthplece (State or Foreign Country) Maryland
	Ba-f show	Director	Usual Residence of Decedent  10a. State  MD  Dorche		ity, Town or Lo	F	ederal	sburg		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 2	ai Dire	10e. Street end Number 6761 Eldorado	Road		10f. Zip Code	1632		10g. Citizen of V	Whet Country? I States
020	within 72 hours after death with the Maryland ena. then "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Maritel Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Wes Decedent Ever in I Armed Forces? 1  Yes 2 No If Yes, Give Yeer or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		? (Specify Yes or N uerto Rican, etc.)	o- 14. Rec Bled Specify	e - American Indian, ck, White, etc. v: White
1215-0	within 72 ho iena. than "natur ma Medical	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12)		(Give	dent's Usuel Occup kind of work done DO NOT use retire	during most of d)	working		)wn Home
Baltimore, Maryland 21215-0020	be filed tal Hygi d other	To Be Co	17. Fether's Neme (First, Middle, Last) William Bo	oston	110	Jiiieiiiakei		Name (First, Middle va Basta	e, Maiden Sumem	
, Mary	nd 2		19a. Intorment's Neme/Reletionship (7) Mary English/Si					oad, Fe		
timore	ages ant of it: if it y or o		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)		compton, cros	osition (Neme of metory or other ple a Sprin	gs Cem	11/14		city or Town, State a Springs, M
Bal	permit. F Depertme Importan any injur		21. Signature of Funerel Service Licens	skin		PO Box	m-Hawk 43, Fe	deralsb	urg, MI	eral Home, PA 21632
1	Physician /Medical Examiner	ner	23a. Pert1. Enter the disease, or compishook, or heert teilure. List only of limited the control of the control	e. Do Ly						Approximate Intervel Between Onset end Deeth
BOX 68/60,	leath certificate be executed attending physician and for use as the bunel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest	3	or es e consequences es e consequences es e consequences es e consequences es es consequences es es es es es es es es es es es es e					
J.	that the cled by the datached	y Physician	Pert II. Other significant conditions con	ven in Pert I.		l tobacco use con	ntribute to the cause of death?			
VITAL Records,	aw requires is been sign 2 should be	Completed by							s en eutopsy formed?	24b. Were eutopsy tindings eveileble prior to completion of cause of deeth?
Ital H	ician: The certificate hi	Ве Соп	25. Wes case referred to medical examiner?				26. Plece ot	1 □ Deeth (Check only	Yes 2 No	1 □ Yes ZNo
n or v	ng Physician: fter this certific merel director,	은	1 Yes 2 No  27. Menner of Deeth Naturel 5 Pending	lospitel: 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpati	28b. Time of Injury	IL SLI DOA	ner: 4 ☐ Nursir ry et rk?		idence 6 Oth	
DIVISION OF	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Injury - At I building, etc. (Spec	Yes 2□No		cation (Street end Number or Rurel Route Number, ry or Town, Stete)			
	To the Hospital or within 24 hours after To the Funeral Dircompletaly filled in	edical C	29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one)	alcien: To the best of my kn ner: On the bests of exemin- end menner stated	owledge, deeth ation end/or Inv	n occurred et the tir vestigetion, in my c	me, date end p opinion, deeth o	lece, end due to the occurred et the time	ceuse(s) end me , dete end placa,	enner es steted. end due to the cause(s)
	To the vithin 2 To the comple	M	29b. Signature end title of cartifier	Bns	MD	29q. Licens	0004	19/0	29d. Date signed	d (Month, Dey, Yeer)
			30. Name and address of person who co	ompleted cause of deeth (Ite	m 23e) (Type,	Print) Road	Blac	les, Di	2 1997	3 MANESH PATE
	Sta Registi	- 6 - 1	31. Dete tiled (Month, Dey, Year)	32. Registrer's Sign	ature 1999	perin	-11	. popar	Kal	



ROLAND E. MARSHALL, SR.

State of Maryland / Department of Health and Mental Hygiene

36329 Certificate of Death

Physician	
/Medical	ŀ
Examiner	ĺ

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Maniel Hyglens. Important: if item 27 is marked other than "naturel", or thems 23s or 28s-4 show any injury or other traumatic event, the Medical Exeminat must be notified at pages.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

n	1. Decedent's Name (First, Middle, Last)		. 1 1					2. Dete of Deel		1999		ol Death
al er	Roland Ellswor: 4s Facility Name (If not institution, give s ROUTE 313 1/4 MII	street and number)			4b F	City, Town	LSBU	ation of Death	4c. Coun	ty of Deeth		
	5. Social Security Number  216-54-7761  Usual Residence of Decedent	7. Age	(In yrs. last birtho	Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day) Dec. 14	Year)	9. Birthp Coun Mar		te or Foreign
tor	10a. State 10b. County MD Dorches	ster	10c. City, Town o		rals	burg			=	ten of Whet Counted Sta  A. Race - Americ Black, White, Specify: Wh  and of Business/Inc  In Struct Sumame) In a m  Town, State, Zip  Town, State, Zip  Town, State, Zip		City Limits
Š	10e. Street and Number			10f. Zip	Code			1	0g. Citizen of	What Coun	try?	
<u>a</u>	6808 Eldorado I	Road			2163	32		1	Jnite	d Sta	tes	
by Funeral Director	11. Marital Status  1 Never Married AN Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		13. Wes Deced If Yes, speci 1 Yes 2	ify Cuban	panic Origin , Mexican, F Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)	BI	ack, White,		•
9	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. De	ecedent's Usual Give kind of worl	l Occupat	tion uring most o	f working	o l	16b. Kind of I	Business/Inc	lustry	
Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5-	18	Carp	ente	er					ion	
990	17. Father's Name (First, Middle, Last) Roland E. Marsl	hall, Sr					,	(First, Middle, I arris				
	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. N	lailing Address	(Street ar	nd Number o	or Rural	Route Number	City or Tow	n, State, Zip	Code)	
	Darlene M. Mars		cemetery,	crematory or of	mer place,	,	i					
	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	20	Easter	1 Snor			,	[1/15]	nurio	CK, I	Mary	land
	Muhad 7- 8	skow					ins-	Esko	w Fun 1sbur	eral	Hom 21	e 632
nedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a cor	nsequence of):					,,,,,,			
BILLIM	d											
y ruysic	Part tl. Other significant conditions con	tributing to death bu	t not resulting in th	ne underlying ca	ause giver	n in Pert I.		23b. Did to				e of death? □ Unknow
completed by								24a. Wes a perform	n eutopsy med?	evi	ere eutopositable pri mpletion deeth?	sy tindings or to ot cause
5								1.2 Y	es 2 No	1,5	Yes 2	2□ No
D	25. Wes case referred to medical examiner?	ospital:					Death	(Check only or				
2	1 1 2 2 2 2 1 NO	1 L Inpatier				4 LI Nursi	- 1	e 5 Reside			/)	
Certification	27. Manner of Death  1 Naturel 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined	28a. Date of trium (Month, Day  1) - 1 O - 9  28e. Place of Injury building, etc.	9 18	38 M		es 2/10/No	21	utome 8f. Location (Si City or Town	bile treet and Nun n, State) R	CICLIC oute	Route N	lumber,
00100	29a. Certifier (Check only one)  1 Certifying Physical Countries (Check only one)		examination and/o				place, er	nd due to the c d et the time, d	ause(s) end r ate end place	nanner es s e, end due to	eted. the caus	e(s)
M	29b. Signature and title of certifier	R W.	acti	1,110		C.M.E					199	6
9	30. Name and address of person who could be seen and address of person who could be seen and	mpleted cause of de		r STREET	T BAL	TIMOR	E, I	MARYLAN	D 2120	1		

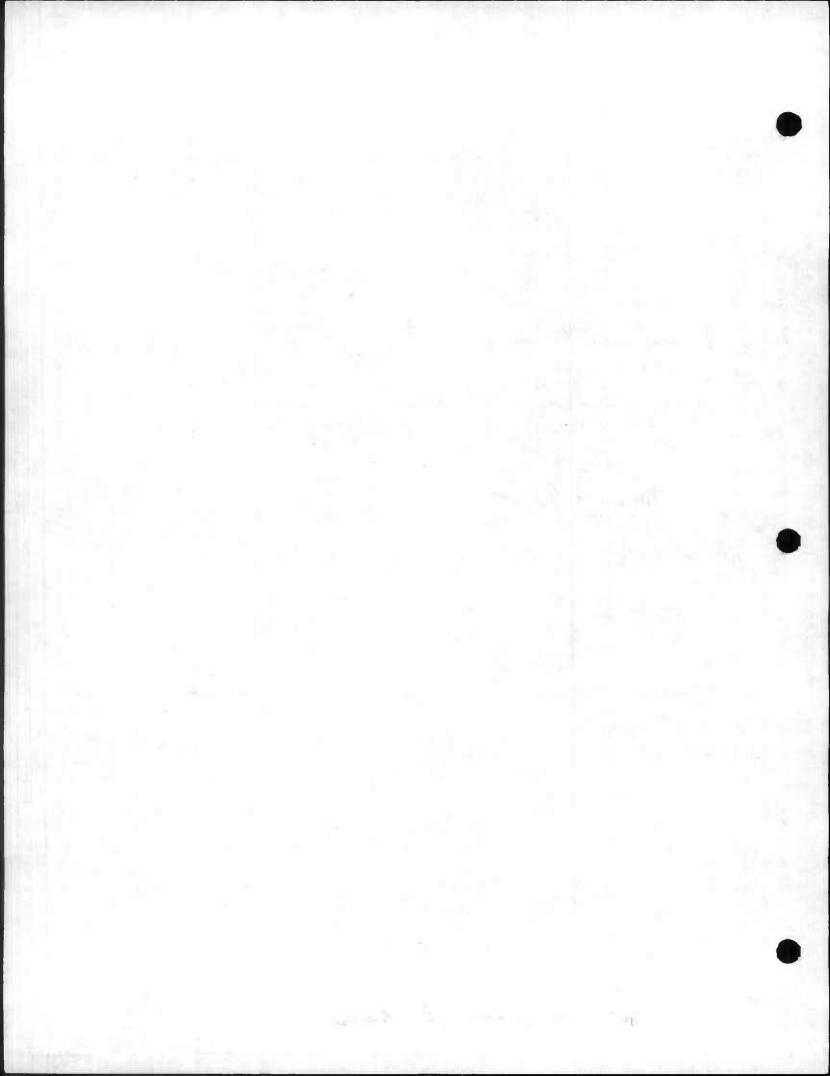
State

Registrar

NOV 1 5 1999

Sporks

32. Registrar's Signature



**Funeral** Director

To Be Completed by Funeral Director

**Physician** 

/Medical Examiner

Deceder's Name (First, Middle, Last)  Mary Ann Mathias  Serving Name (First, Middle, Last)  Mary Ann Mathias  Serving Name (First, Middle, Last)  The Memorial Hospital  The Memorial Hospital  The Memorial Hospital  The Memorial Hospital  Serving Name (First, Middle, Last)  The Memorial Hospital  The Statum Road  The Memorial Hospital  The Mem		Pleas					nk. Assure A	-	_	
Deceded From Name (First, Modifies, Later)   Development State   State of Development   Developmen									95	9 36330
Mary Ann Mathias  **Fortily Near Michael and Frankishon, piese states and numbers  The Memorial Hospital  **The Memorial Hospital  The Memorial Hospital  **The Memorial Ho	1. Decedent's Nama	(First, Middle,	Last)					2. Data of Deet	th	
The Memorial Hospital  Social Social Social Number  Lind 20 F 6.99 yr.  Modelly 19 F 19 9 yr.  Modelly 19 F 19 9 yr.  Modelly 19 F 19 9 yr.  Modelly 19 F 19 9 yr.  Modelly 19 F 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 9 Yr.  Modelly 19 P 19 P 19 9 Yr.  Modelly 19 P 19 P 19 9 P 19 P 19 P 19 P 19 P 1								October	28,	1999 0518
5. Social							4b. City, Town, or I	Location of Death	4c. County	of Death
2012281078  In Maria 100. County  M. Caroline    Too. Colors   Too. City, Town or Location   Too. City, Town or Location   Too. City, Town or Location   Too. City, Town or Location   Too. City Color   Town or Location   Too. City, Town or Location   Too. Street and Number   Town of Location   Town or Location   Town				the same of the sa	· · ate along	H Hadar 1 YE		Cots of Birth		
106. Cary   106. Cary   106. Cary   106. Cary   107. Town or Location   104. Spc Code   107. Spc Code   107. Spc Code   107. Spc Code   108. Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc Code   108. Amen Force of the Spc No. Specific Spc No. Spc No. Spc No. Spc No. Spc No. Spc No. Sp	21228107	78							,1930	9. Birthplaca (Stata or Foraign Country) Va •
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109. Street and Number   109. Street and Number   109. Zep Code   109. Citizan of What Country?   109. Statum	Md.	Carol	ine	Dente	on					1 ☐ Yas 27 No
Newer Married   Amed Forcest   Lives 2 (DNo   Single Control		nber						16	-	
Elementary (Septe (North phighast grade completed)   College (1-4or 5+)   College (1-4or 5+)   HOME maker	1 Nevar Married		Armed Force  ad 1 Yas 2 If Yas, Giva	rcas? 2[XNo /a	If	If Yas, specify C	Cuban, Maxican, Puarto	rto Rican, atc.)	Specify Am	ck, White, etc. ,white/ Merican India
Paul 19s. Informent's Name (First, Middle, Maiden Sumanna) 19s. Informent's Name/Relationship (Type, Print) 19s. Informent's Name/Relationship (Type, Print) 19s. Mailing Address (Street and Number or Rural Route Number, Chy or Town, State, Zip Code) 7195 Statum Road, Denton, Maryland 21629 20s. Mathod of Disposition 1 Durial 2 (Okramation 3   Ramoval from State 4   Donation 5   Other (Specify) 20s. Mathod of Disposition (Street and Number or Rural Route Number, Chy or Town, State, Zip Code) 7195 Statum Road, Denton, Maryland 21629 20s. Mathod of Disposition (Name of certain State) 20s. Pales (Specify) 20s. Pales (Specify) 21. Sequentially Funeral Service Licensees 22s. Name and Address of Facility Moore Funeral Home, P.A. 21629 23s. Pales (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Book, or heart feature. Left only one cuses on each fine.  23s. Pales (State and Specify) 24s. Wes as a consequence of): 25 Due to (or as a consequence of): 26 Due to (or as a consequence of): 27 Due to (or as a consequence of): 28 Sequentially list conditions, resulting in death) Last 28 Due to (or as a consequence of): 29 Due to (or a	(Specify	ify only highast (	grada completed)		(Giva k lifa. D	kind of work dor DO NOT use rati	ona during most of work stired)	orkina		
198. Informent's Name/Relationship (Type, Pinnt)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland 21629   71.95 Statum Road, Denton, Maryland Route Relative Road, Road Road Road Road Road Road Road Road		First, Middle, La		isenber		Cinci	18. Mother's Nam		Maiden Surnam	· ·
Capital 2 (Cramation 3   Removal from State   Capital Crematory   10/31   Dover, Delaware   10/31   Dove			Ip (Type, Print)	19	9b. Mailing					
Moore Funeral Home, P.A.  12 South Second St., Denton, Maryland  23a. Parl. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast,  Approximate interval Batween Conset and Death  Immediate Cause (Final disease or condition)  a. Cororal Artery Disease  Due to (or as a consequence of):  Due to (or as a con	1 🗆 Burial 2 💢	Cramation 3		cemate	tery, cram	netory or other p	place)			
23a. Parfi. Entar tha disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.    Approximate the interval Battween Onset and Death   Concept	21 Segriature of Fune	eral Service Lic	PMa	m_	Mo	oore F	uneral H	ome, P.	A. Nenton	
disease or condition resulting in death)  Due to (or as a consequence of):	shock, or heart	t failura. List on	only ona ceusa on aad	ach lina.	o not anta					Approximate Intarval Batween
Section   Control   Cont	disaasa or condition		. Cor	ONAL Dua to (or as	a conseq	they	1) 1)	sease	<u>ک</u>	years
Cause (Disease or Injury that initiated evants resulting in death) Last  Dua to (or as a consequence of):    Dua to (or as a consequence of):   Dua to (or as a consequence of):	if any, laading to imm cause. Entar Undarly	madiata rlying	b	Dua to (or as a	a consequ	uanca of):				
1   Yes 2   No 3   Probably 4   Deficience	Cause (Disaese or In that initiated evants	njury	c	Dua to (or as a	a consequ	Jance of);				
1   Yes 2   No 3   Probably 4   Deficience	Dest II Other signific	and condition	a contributing to day	the but not resulting	- in the ur	deduing cause	cion in Part I.	23b. Did to	-hanno use co	Thurs to the cause of death?
25. Was case referred to medical axaminer?  1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   Normal State   Yes   Ye	Lu		0	~ ~ ~		дапунну	given ner was			
25. Was case referred to medical axaminar?  1	Co.	uge	stive	e he	ext	; Fo	rifure	perform	med?	completion of causa
Axaminar/ 1								1 🗆 Ye	es 20-No	1□Yas 2□H0
1 Swatural 5 Panding (Month, Day Year) Injury Work? 2 Accident invastigation 3 Suicida 6 Could not be determined determined. 28. Placa of Injury - At home, farm, streat, factory, office 28f. Location (Street and Number or Rural Routa Number,	axaminar? 1 ☐ Yas 2 ☐ No	40	1 Uln		-	IL SEL DON	Othar: 4 Nursing H	Homa 5 ☐ Raside	ence 6 Othe	
determined 288. Place of Injury - At home, streat, factory, office	1 Chatural 2 Accident	5 Panding invastigat	(Month,	h, Day Year)	Injury	M 1	Work? 1 ☐ Yas 2 ☐ No			
29a. Certifier 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated.	4 🗆 Homicida	detarmine	ned 28a. Placa o building	ng, atc. (Specify)				City or Town	n, Stata)	

State Registrar

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after deeth.

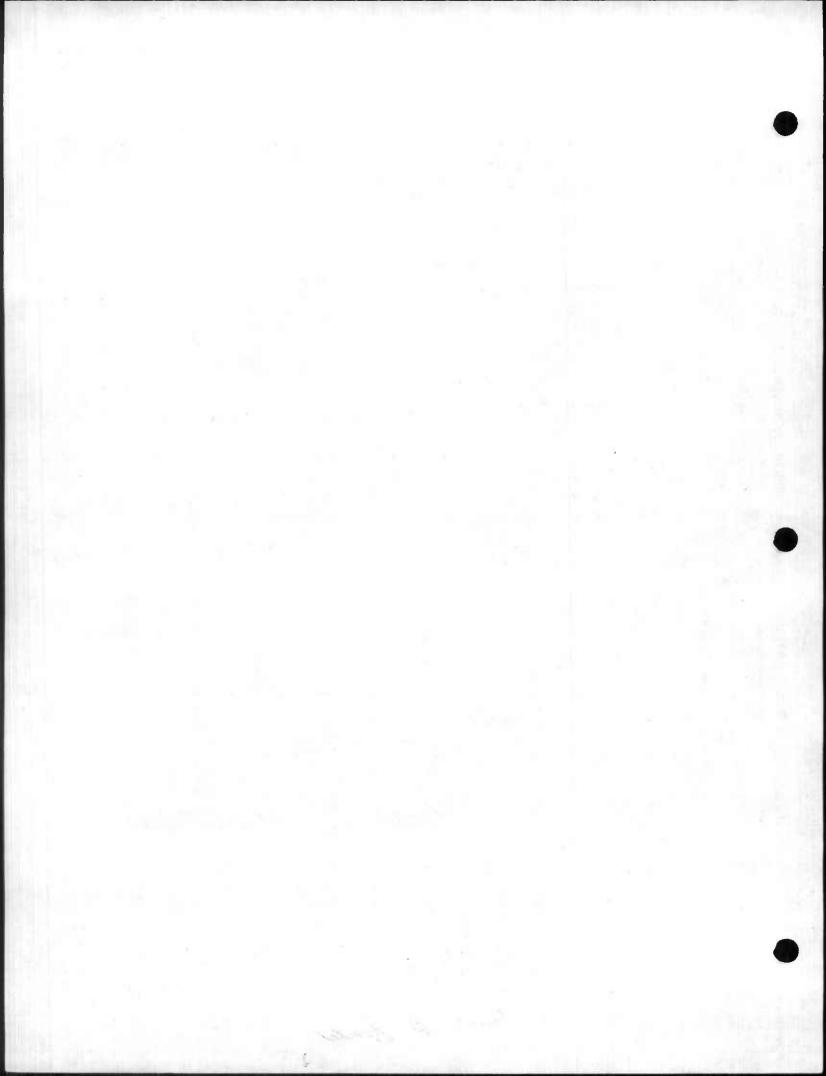
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

31. Data filed (Month, Day, Year) NOV - I 1999

James



30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Nov 12 1999 Russell Clifton Melton Jr /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Centreville Corsica Hills Nursing Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1₩ M 2□ F Months Days July 15,1927 Director 226-24-5998 Usual Residence of Deceden 10e Stete 10h County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Directo Greensboro Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7-15-21639 315 Sunset Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No 1943— If Yes, Give Yeer or Dates: 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1950 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Do permit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If item 27 is marked other than ' College (1-4or 5+) Elementary/Secondery (0-12) Bus Driver 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Bessie L Porter Russell Clifton Melton Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Greensboro, Maryland 21639 PO Box 423 other Marie Melton 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 6661 21 Signature of Funeral Service Licenses 22. Name and Address of Fecility Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Gargrene & foot /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner**

physician and s tha buriel-trans

Physician/Medical à Completed funaral diractor, Be 10 Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

24a. Was an eutopsy performed? 1 ☐ Yes 2 ☐ Colo

completion of cause of deeth?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Plece of Death (Check only one)

28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Due to (or es e consequence of):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Tig Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 29c. License number

30. Name and address

032036

Sorace 2008 Of Doroch Drue Chickey MU 2/6/9 prove

31. Dete filed (Month, Dey, Year) NOV 1 5 1999

25. Wes case referred to medical exeminer?

5 Pending

Investigation

1 Yes 2 No

27. Manner of Deeth

Natural 2 Accident

3 ☐ Sulcide

4 Homicide

2. Registrar's Signature

Registrar DHMH 16 Rev 6/95

State

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Division of Vital I

Melton

2444600

Records,

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death.

or Attendent of the date of the Director:

ne Hospital or Atte n 24 hours efter de ne Funeral Directo pletaly filled in by ti

To the Hosp within 24 hor To the Fune completely fi

edical

Examiner

transportation

Specify:

16b. Kind of Business/Industry

14. Rece - American Indien, Black, White, etc.

white

4c. County of Death

Queen Annes

USA

20c. Location - City or Town, Stete

Nov 15,1999 Greensboro, Maryland

21639

Approximate fnterval Between Onset and Death

36331

Birthplace (State or Foreign Country)

10d Inside City Limits

1K Yes 2 No

South Carolina

3. Time of Death

4:30 AM

IM

1 70s 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to

1 ☐ Yes 2 ☐ No

a a se la constante de la cons A SECTION OF THE SECT The probability of the same of the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36332 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Yaar **Physician** Anna Louise Mace 9 1999 November 7:30 PM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Caroline Nursing Home Denton Caroline If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2X F Yrs Director 212-16-1719 81 July 30,1918 Maryland Usual Rasidence of Dacadant 10a, Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner ment be notified at 1 X Yas 2 □ No Maryland Caroline Greensboro Direct 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 102 Hobbs Street 21639 USA permit. Pages 1 and 2 should be filed within 72 hours efter death \text{Department of Health and Mental Hyglene. Important: if flem 27 la marked other than "natural", or thems 23 any Injury or other traumatic avant, the Menical Experiments mainly injury or other traumatic avant, the Menical Experiments. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No Specify þ 3 1 Widowed 4 □ Divorced white Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) supervisor Manufacturing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) George Langrell Sophia Baynard To 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 27499 Liden School Rd John Mace Jr Federalsburg, Maryland21632 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Greensboro Cemetery 11-13-99 Greensboro, Maryland 21. Signatura of Funaral Service Licanses 22. Nama and Addrass of Facility any ir Fleegle & Helfenbein Funeral Home PO Box 160 Greensboro, Maryland 21639 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Daath Physician breast Cancer /Medicai Immediata Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consaquanca of): Examiner Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): physician er Physician/Medical Dua to (or as a consequence of): for use as Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the deteched signed by t 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Ware autopsy findings available prior to completion of causa of daath? been si 24a. Was an autopsy performad? Completed certificate hes t 22 No 1 ☐ Yas 2 No To the Hospital or Attending Physician: I within 24 hours effer death.

To the Funeral Diractor: Affer this certifical completely filled in by the funeral director, p Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Deeth 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Netural 5 ☐ Pending 2 □ No invastigation 1 ☐ Yas 2 Accidant 6 Could not be detarmined 3 Sulcide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha cause(s) and menner es stated 29e Cartifia Medical 2 Medical Examiner: On tha basis of axaminetion end/or invastigetion, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) end mannar statad. 29b. Signatura and titla of certifian 29c. Licanse number 29d. Data sloned (Month. Dav. Year) 03

State Registrar James

31. Data filed (Month, Day, Year) 1995

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print)

32. Registrar's Signatura

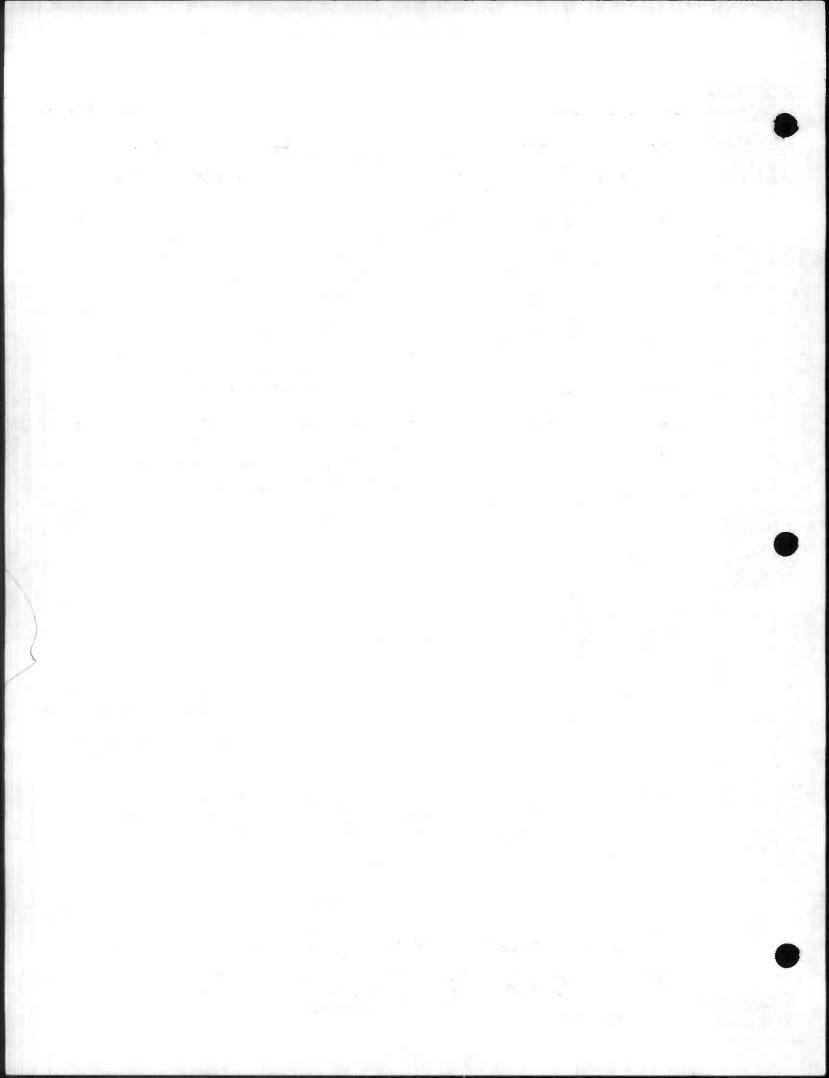
with the Marylend

Baltimore, Maryland 21215-0020

The lew requires that the death certificate be executed

Olvision of Vital Records, P.O. Box 68760,

pue



State of Maryland / Department of Health and Mental Hygiene Q Q

				Cert	ificate of	Death	Red	2. No.	2 0	0333
		1. Decedent's Nama (First, Middle, L.	nst)				2. Data of Death		Marin .	3. Tima of Death
	ysician	Arnold Leroy	Olsen				October	Day	Year	2:26 PM
	Medical caminer	4a Facility Nama (If not institution, gi				4b. City, Town, or	Location of Death	4c. County		2774
	eral	1	Sex 7. Age (In yrs	last birthday)	If Undar 1 Yaar Months Days				Countr	**
	0.01	Usuat Rasidence of Decedent			1.		DOLY X2	,1931	New 3	COLK
/lan	14	10s. Stata 10b. County	10c. C	ity, Town or Loca	ation				10	d. Inside City Limits
the Man	be notified at Director	Maryland Harfor	od	Bel Air	10f, Zip Code		10	g. Citizen of	What Counts	1 ☐ Yas 2 💢 No
death with the Maryland	Z 0	1405 Beetree (			2101			U	SA	
- P E	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in I Armed Forces? 12 Yas 2 No If Yes, Giva Year or Datas:		as Decedent of Yas, specify Cul ☐ Yes 2☑ No		Specify Yas or No- rto Rican, atc.)	Bla	ce Amarica ck, Whita, a y: Whit	tc.
15-002 72 hours	a bet	15. Decedent's E (Specify only highest gr		16a. Decede	nt's Usual Occu	pation during most of we	nd ind	6b. Kind of B	usiness/Indu	istry
within then	r, the Medical	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	neer	ed)		releco	mmınic	cations
		17. Father's Nama (First, Middla, Las	")	1	11001	18. Mother's Na	ama (First, Middle, Ma			240110
Maryland d 2 should be file th and Mental Hy 7 is merked othe	o Be	Harry (nmn) (	Olsen			Berdin	e (nmn)	Joh	nson	
Taryla 2 should and Men	끝	19e. tnformant's Name/Ralationship		19b. Mailing	Address (Stree		Rural Route Number,			Code)
- C - N	ner traum	Mary Olsen / Wife		1405 B	eetree		Air, MD		, 0,410, 2,5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
0 805	or other	20a. Method of Disposition 15 Burial 2 Cremation 3 [		Place of Disposit cemetery, crema	tion (Name of story or other pla	ace)	Data 20	Oc. Location	City or Tow	m, Stata
Pages nant of mt: If the	o Au	4 Donation 5 Other (Speci		aker's C	'emeters		11-3-99 A	ordes.	n Mars	zland
Baltimore permit. Pages 1 to Department of He important: If Nem	ang injury	21. Signature of Funerial Service Lice	nseen A				lome, P.A.	ALUCE.	Hereit	Teller
m 88 E	2 8	> Helle	1 Comas				reet, Bel	Air,	Maryla	and 21014
		23a. Part1. Enter the chaese, or con shock, or heart failure. List only	plications that coused the dea						1	Approximata Interval Batween
oertificate be executed and mains physician and	e as the burial-transit	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. liver fair Due to (	or as a conseque	ence of):		bleed			
death cert eatherding	or u									
. 0 0	Physician/	Part It. Other significant conditions	contributing to death but not rai	sulting in tha und	lerlying ceuse g	iven in Part I.	23b. Dtd tob	acco use co	ntribute to	the cause of death?
IS, P.O. BO) as that the death ce igned by the attend	be detac by Phy						1 □ Yes	2 DKNO	3 Probe	ably 4 Unknown
COTO v requir	ahould leted						24a. Was an performe		com	ra autopsy findings ilable prior to ilable prior to inplation of cause eath?
E & 5	Page To						1 ☐ Yas	2 DINO	10	Yas 2□ No
Vital Indicate contificate	Be C	25. Wes cese referred to medical axaminer?				26. Pleca of De	eth (Check only one	)		
Of Vita Physician: this certific	P P	1 Yas 2 No	Hospital: 1 tnpatient 2	ER/Outpatient	3 DOA	her: 4 Nursing	Homa 5 ☐ Rasidan	ce 6 □Oth	nar (Specify)	)
VISION Of Attanding Physic death.	funeral tion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	M 1 [	ıry at ork? ] Yas 2 □ No	28d. Dascribe how	injury occur	red	
Division of all or Attending Physis after death.	completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	3 ☐ Suicide 6 ☐ Could not be determined		oma, farm, stree fy)	t, factory, office		28f. Location (Stre City or Town,		ber or Rural	Routa Number,
To the Hospital within 24 hours To the Funeral	edical		nysician: To the best of my knominer: On the basis of axamine and manner stated.							
6 등 6	Me	29b. Signature and titla of certifier			29c. Lican	sa number	290	d. Date signe	d (Month, D	lay, Year)
	_	I Androaller	be MD		Dec	· non-	1	Cholo	ar 21	1999
	+	30. Nama and address of person who	completed cause of death (Ite	m 23a) (Type, Pr	rint)	0000	tment of	-100	01 31	)1 \ 1
	Z	Dodres Hank	NO E	2 20 1 Li	3011	2	1- toward	aficas	00	0.00
	State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	eture eture	A LIMING	K, Clebay	TO TIVENTE	200	W SU	ngery
Re	gistrar	NOV 0 3	1999 Dener	w A	do					

DHMH 16 Rev 6/95

De Olsen, Arnold

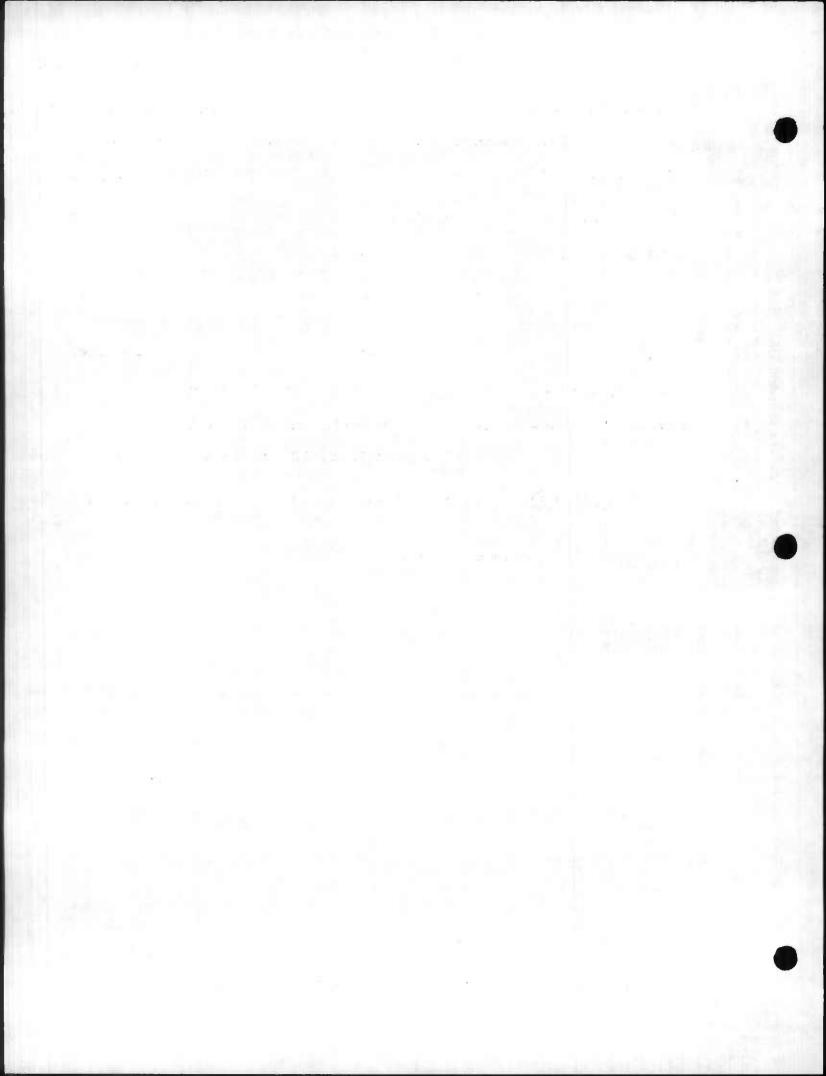
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State of Maryland / Department of Health and Mental Hygiene 99 36334

				Cer	tificat	e or L	Jealn			Reg. No.		00004						
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Jame	s Roosev	elt Pr	octor					N	Month Iovemi	per 6,	199	9 2:30						
	(If not institution, given					4	b. City, Tov		ation of Deet		nty of Deeth							
2450	Davis Rd	MD	MD Waldorf, Char.						rles									
5. Social Security	Number 6.5	Sex		lest birthday)	If Under		If Under 2	4 Hrs.	8. Dete of Bi	th DEC.		nplece (Stete or For						
212-6 Usuel Residence	0010	M 2□ F	45	Yrs.	Months	Deys	Hours	Min.	8. Dete of Bi (Month, Do 2-22-	-53	Mar	yland						
10a. Stete	10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Lin						
MD	Charle	S	Wa	aldorf								Mayes 2□						
10e. Street end N	lumber				10f. Zip	Code				10g. Citizen o	of Whet Cor	untry?						
2450 D	avis Rd				20	0603				USA								
11. Marital Status		12. Wes Dece	dent Ever in L	J.S. 13. V	Vas Dece	dent of His	spenic Orlg	in? (Spec	cify Yes or No	o- 14. R	Race - Amer	ricen Indien,						
	arried 2 Merried 4 Divorced	Armed Fo 1 Tes If Yes, Giv Yeer or De	2 XNo				n, Mexican, Specify:	Puerto F	licen, etc.)		Black, White city: B1							
	15. Decedent's E	ducation ade completed)		18a. Deced (Give	lent's Usu- kind of wo	el Occupa	ation luring most	of workin	g	16b. Kind of	Business/I	ndustry						
Elementery/Se	condary (0-12)	College (1	-4or 5+)	1			)			0016	Emm 1	01104						
12				Me	chai	nic				Self-	-	oyea						
17. Father's Nem	e (First, Middle, Last	t)					18. Mother	's Name	(First, Middle	, Maiden Sum	ame)							
John	R. Proct	or					Mar	y G.	. Proctor									
19a. informent's	Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street e	et end Number or Rural Route Number, City or Town, Stete, Zip Code)											
Phyllis Proctor - sister 2450 Day							Road	d, W	aldo									
20a. Method of Disposition  1																		
21. Signature of Funeral Service Licensee 22. Name end Address of Fecility																		
I Un Quat												1 1 00						
M00191 Adams Funeral Home 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reshock, or hear failure. List only on cause on each line.											Mary							
shock, or h	an failure. List only	one cause on e	ech line.	th. Do not ente	er the mod	e or aying	g, such es d	erdiac or	respiretory e	errest,	1	Approximete Interval Between Onset end Deat						
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Sequentially list if eny, leading to	conditions,	or es e conseq	uence of):															
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that initieted eve resulting in death	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events Due to (or es e consequent cause). Enter Underlying Ceuse (Diseese or Injury that initieted events Due to (or es e consequent cause).																	
		u									1							
Pert II. Other sig	nificant conditions	contributing to death but not resulting in the underlying cause given in F							23b. Did	tobacco use	contributa	to the cause of de						
									1 🗆	Yas 2 N	o 3 Pr	obably 4 Unk						
									24e. Was	s en eutopsy ormed?	(	Were eutopsy findir						
												completion of ceus of deeth?						
									10	Yes 2 X X	,	1 ☐ Yes 2 ☐ No						
	erred to medical						26 Place	of Death	(Check only									
25. Wes cese ref	7	Hospital:	nnationt 2	FB/Outpation	t 3 🗆 🗅	Othe				idence 6 🗆	Other /Sne	city)						
exeminer?	1 I Inpatient 2 ER/Outpatient 3 DOA									how Injury oc		,/						
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exeminer? 1 Yes 24 27. Manner of De 1 Neturel 2 Accident 3 Suicide	5 Pending investigation	on 290 Place	of Injury - At h	ome, farm, stre	eet, fector	y, office		2	27. Manner of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Re. Dete of Injury 4 Determined 2 Se. Dete of Injury 4 Describe how Work? 2 Sec. Dete of Injury 4 Describe how Work? 2 Sec. Dete of Injury 4 Describe how Work? 1 Yes 2 No 286. Dete of Injury 4 Nork? 1 Yes 2 No 286. Dete of Injury 5 Pending investigation 3 Suicide 4 Homicide 286. Dete of Injury 4 Nork? 1 Yes 2 No 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Detection work? 286. Det									
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDMENT #28F-WCHD 11/9/99 EPW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10/4N Howard PARSONS November 4 /Medical 4e Facility Neme (II not institution, give street and number)
PENINSULA REGIONAL MEDICAL 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 100M 20 F Yrs. 227-14-558 Director 31-221/1R6.NIA Usual Residence of Decedent 10a Stele 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No ACCOMACK Director Accompe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò N, Smith Rel 4441 ted Nerna 23a mary 23301 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Dives 2 □ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Status Black, White, etc. 1 Never Merried 2 Married Black Baltimore, Maryland 21215-0020 ò 1 Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "r any injury or other traumatic avant College (1-4or 5+) Elementary/Secondery (0-12) Teacher System School 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1855-11-128 Walter Parsons MCIVER KATE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2334 Rd : Accompe Un
20c. Location - City or Town, Stete Florence GARSONS WIFE 20b. Place of Disposition (Name of cametery, crametory or other place) N Smith many 20e. Method of Disposition Date Buriel 2 Cremetion 3 Removel from State Seymon 11/13/99 Accompc, va 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home 22. Name and Address of Facility UN 500 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Decomperua 23301 Approximete Interval Between Onset end Death **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Multiple Traum Im Examiner Due to (or as a consequence of) Examiner ettending physicien end for use es the bunal-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medicai Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) examiner r 12 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dec. 1 Natural 1 Yes 2 No MVA 1000 M 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) POCO MOKE

Division or Attending To the Hospital o within 24 hours at To the Funeral D

24 hours al Evaneral D letely filled i

To the Fun

6 State Registrar

**DHMH 16 Rev 6/95** 

Medical

Chilstopher S.
Dele filed (Month, Dey, Year) Snuder

4 | Homicide

(Check only one)

29b. Signeture and title of certifier

29a. Certifier

0.0.

450457 DIME

t Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Podkomoke, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALISOVIA, 104 MIHOS 512 201 32. Registrar's Signature

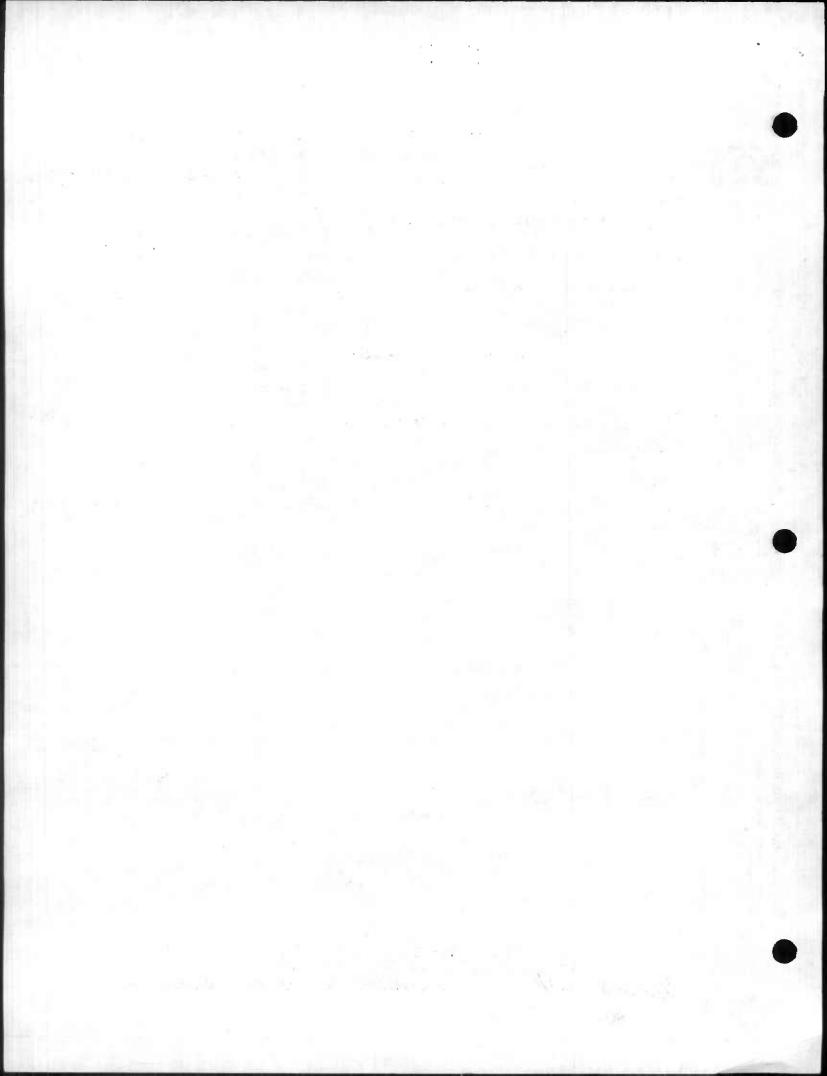
29c. License number

NOV 0 9 1990

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Rt. 13 901d Snawhin Kd

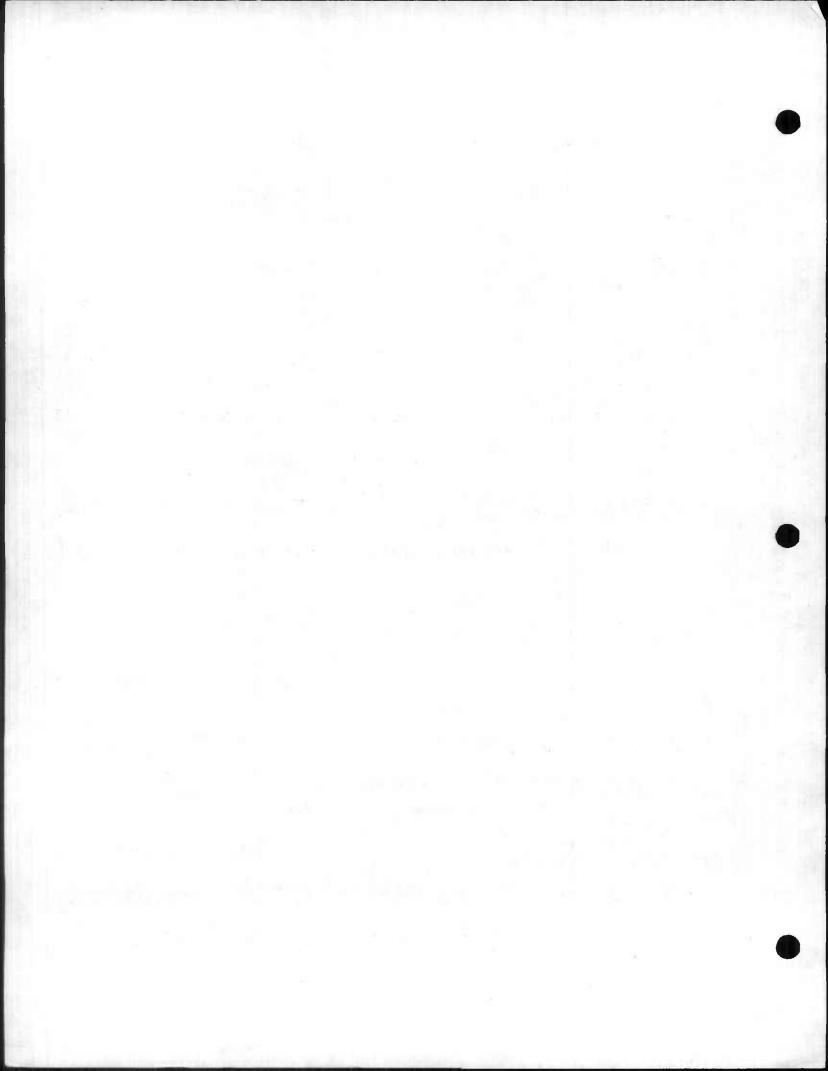
**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey Month Year **Physician** Virgil Clifton Parker November 5,1999 1935 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Talbot The Memorial Hospital Easton 8. Dete of Birth
(Month, Day, Year)
June 6, 1930 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 6. Sex 1 M 2 ☐ F 9. Birthpleca (State or Foreign **Funeral** Maryland Hours 578-42-0358 69 YES **Director** Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show main be notified at 1 Yes ZE No Directo Maryland Cambridge Dorchester Virgil Parker & 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Berrs 23a 5509 Whitehall Rd. 21613 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Nevar Married 2 Married altimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: If Yes, Give Year or Dates: 1954-56 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mortal Hygiere. Important: if Item 27 is marked other than \*n any Injury or other traumatic event the Man Elementery/Secondary (0-12) College (1-4or 5+) 12 Supervisor Canning 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Orian Stewart Parker, Sr. Anna Frischknecht 20 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma D. Parker/Spouse 5509 Whitehall Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dorchester Mem. Pk. 111-9 | Cambridge, MD ature of Funaral Service Licenses 22. Name and Address of Fecility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 concuell 234. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, mock, or heart failure. List only one cause on each line. Approximata Intervet Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical neumonia 50 Examiner Examiner The lew requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Last Due to (or es a consequence of): 68760 Completed by Physician/Medical Due to (or as a consequence of): P.O. Box signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? tiple decubiti 24a. Wes en eutopsy performed? evebrovascular accident 2 K No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 XNo 27. Manner of Death 1 Avatural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature and title of cumilier 29c. License number 035784 29d. Date signed (Month, Dey, Year) me 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Allen, M.D., 219 South Washington St., Easton, MD 21601 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Day **Physician** Nov. 4, 1999 ELIZABETH PETENBRINK 1:40 p.m. VIRGINIA /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ALLEGANY DEVLIN MANOR NURSING HOME CUMBERLAND If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2X F Days Months Yrs. Director 85 214-07-2617 Jan 27, 1914 MD **Usual Residence of Decedent** Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland ment of Health and Mental Hygiens.

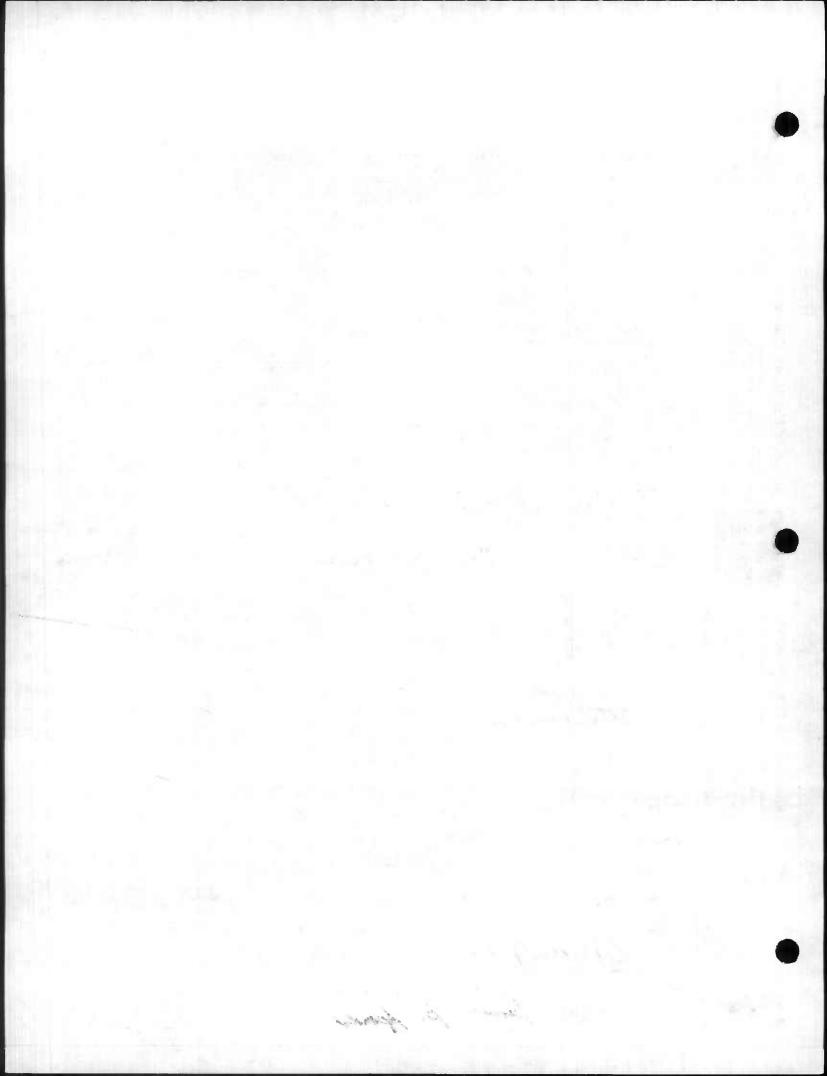
ant: If Hem 27 is marked other than "natural", or hems 23a or 28a-f ahow ury or other traumetic event, the Hedical East most must be notified at 10c. City, Town or Location 10n State 10h County 10d. Inside City Limits XXYes 2 □ No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Somerville Avenue 21502 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, atc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert M. Raupach Leah V. (Leydig) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert F. Willingham -- son 507 Lakeview Court; Stafford, VA 22554 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete WBurial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 11/08 Mt. Lebanon Cemetery Glenco, PA 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licenser Cumberland, MD 21502 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each len. Approximate Intarvel Batween Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Rene tell Examiner Due to (or es e consequence of): Physician/Medical Examiner ettending physician end for use as the burlet-transit The lew requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or es a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown allepenne of Vital Records, þ cata has been significant page 2 should be 24b. Were autopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed completion of cause of daeth? certificata has 22000 1 Tes 1 ☐ Yes 2 ☐ No or Attanding Physician: director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) axaminer? Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Vursing Home 5 Rasidence 6 Other (Specify) After this To the Hospital or Attanding Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral o 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation Digatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Decertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar es steted.

2 Bedical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end dua to the cause(s) and mannar stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Two. D17565 Nov. 4, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes Anthony Bollino, Jr.; 922 National Highway; LaVale, MD 21502

DHMH 16 Rev 6/95

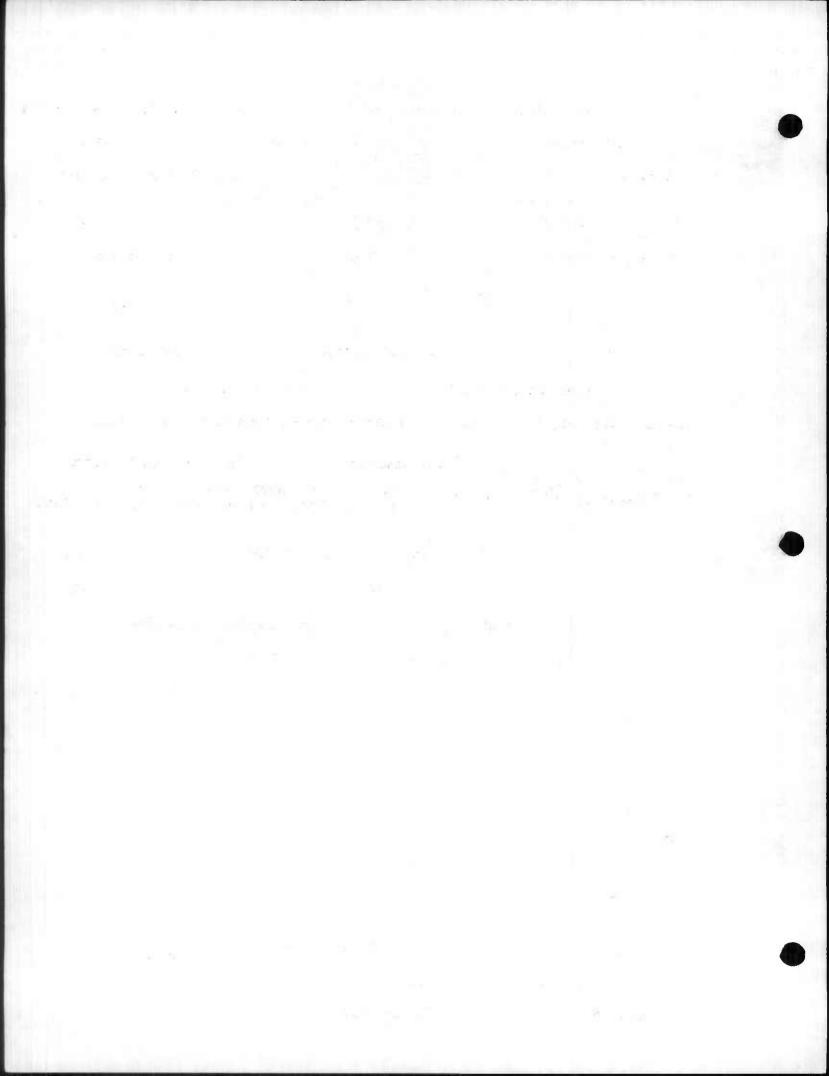
State Registrar 31. Date filed (Month, Day, Year) NOV 0 5 1999 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 99

99 363

					Certificate	of D	eath		Reg. No.	W	00	330	
Dhusi	-ion	1. Decedent's Neme (First, Middle, La	st)					2. Date of D		Yeer	3. Tir	me of Death	
Physic /Med		D 4 M 4 D'un's									999	12:40PN	
Exam		4e. Fecility Neme (If not Institution, give				4b	. City, Town, or	Location of Dee		7, 19 ounty of Deat	th		
		1127 Market Stree					Denton			Card	oline	)	
Funera		5. Social Security Number 6. S	M 2□ F		Months	1 Year Days	If Under 24 Hr. Hours Min	. (Month, L	lirth Dey, Yeer)		hplece (Si	tate or Foreign	
Directo		215-26-5446 Usuel Residence of Decedent	69		Yrs.			March	15, 19	30 Ma	aryla	nd	
bu m		10a. Stete 10b. County	10c. C	ity, Tow	n or Location						10d. Insi	de City Limits	
Mary	ō	Maryland Carolin	10		Denton						15	Yes 2□No	
the 128s	Director	10e. Street end Number			10f. Zip (	Code			10g. Citizer	n of Whet Co	ountry?		
3a o		1127 Market Stree	<u>.</u>		216	29			Unite	ed Stai	tes		
5-0020 72 hours efter deeth with the Marylend naturel', or frems 23s or 28s-f show alest Enaminer must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in	U,S.	13. Wes Decede		penic Origin? (	Specify Yes or N	-	Race - Ame	nican Indie	en,	
of the care		1 Never Married 2√2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 Yes 2			no Hican, etc.)		Bleck, White	e, etc.		
ours Fell,	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes:		TLI Tes 2	DAT INO	<i>эрвспу</i> :			pecify: Caucas:	ian		
Z1Z15-0020 d within 72 hours efter deeth with the Marylen giene. r then "natural", or terms 23a or 28a-f show the Mexical Example must be notified at	Completed	15. Decedent's Ed (Specify only highest gre	ducation ade completed)	16e.	Decedent's Usual (Give kind of work life. DO NOT use	Occupat	ion iring most of wo	orking	16b. Kind	of Business/	'industry		
within within than the Men	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)					17/	Cox	pente	<b>-</b>		
other I		11 HS Grad.  17. Fether's Neme (First, Middle, Last.	)		Self-emp			me (First, Middl		-	_		
Maryland d 2 should be file th and Mentel Hy 7 is merked othe traumatic event	Be						_			,			
arylan should be nd Mentel marked o	To	Luther  19a. Informant's Name/Relationship (	James Pippi		. Meiling Address (	(Street or	Rosa		Colema bar City or T		Zin Cadal		
end 2 sho selth and n 27 is m		Margaret Ruth Pig			27 Marke						1629		
re, Maryland 21218 at end 2 should be filed within f Health and Mentel Hygiene. Item 27 is marked other than other traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event, the Mentel traumatic event.		20a. Method of Disposition	1		Disposition (Nemo			Dete		tion - City or	Town, Ste	ite	
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ortan		21. Signature of Funeral Service Licer	De	entor	Cemeter 22. Neme end		of Fecility	11/10	Dentic	on, Ma	гутан	Iu	
Depentit. Depentrational any injury once.		( Xandable	Place	1				me, P.A.					
		23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	eth. Dor	12 Sou	ttli S	such as cerdia	Street,	Dentor	, Mar	ylanc Approx		
Physician	10	shock, or heart failure. List only	one cause on each line.						ř	i	Interve Onset	el Between end Death	
/Medicai		Immediate Ceuse (Finel disease or condition	Altron	SIDI	untio f	Hoai	t der	rane		1	400	av.	
Examiner		resulting in death)  Due to (or es e consequence of):											
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cete be executed physician and sthe buriel-trensit	Examiner	Sequentially list conditions,	Due to	or es e c	consequenca of):								
be ex		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	End oft	He	revala	dere	are d	halifour	depe	dout			
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Se es	≥		a Ceselono	Vale	ulan d	ured	u with	RY flat	urfair	esso	4 20	uss	
Attending Physician: The lew requires thet the death certificate be executed at death.  •ctor: After this certificate has been signed by the ettending physician and by the funeral director, page 2 should be deteched for use as the buriel-trensit	Physician/												
of the d	lys	Part II. Other significent conditions of	ontributing to death but not re	sulting In	the underlying car	use giver	in Pert I.		_			uee of death?	
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OVISION OF VITAL RECORDS, Proverties thet effer death. Director: After this certificate hes been signed to by the funeral director, page 2 should be detail	ed by								s en eutopsy	24b.	Were auto	psy findings	
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VICIAN: The certificate rector, pag	Be C	25. Wes case referred to medical					26. Piece of De	eath (Check only				2010	
ysici is cer direc	To E	examiner? 1 ☐ Yes 2 PNo	Hospital: 1   Inpatient 2	] ER/Ou	tpetient 3□ DOA	Other		Home 5 Res		☐Other (Spe	cify)		
og Ph ter th		27. Manner of Death 1 → Natural 5 □ Pending	28e. Date of Injury (Month, Dey Yeer)		ime of 28	Bc. Injury		28d. Describe					
endir eath. or: Af	Certification:	2 ☐ Accident investigation	1		М		es 2 🗆 No						
r Att	E E	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At I building, etc. (Spec	nome, fa	rm, street, factory,	office		28f. Location City or To	(Street end Nown, Stete)	lumber or Ru	ural Route	Number,	
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Hosp 24 ho Fune tely f	edical	29e. Certifier Certifying Ph	yelclen: To the best of my kn niner: On the besis of examin end manner stated.	owledge ation end	, deeth occurred et dor investigetion, i	t the time in my opi	, date and plac nion, death occ	e, end due to the urred et the time	e ceuse(s) en e, dete end pla	id menner es aca, end due	steted.	use(s)	
To the Hospital or Attending Physician: The I within 24 hours effer death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Med	29b. Signature end title of certifier	number	I	29d. Date 9	signed (Monti	h. Dev Ye	aar)					
6 7 K 1							/						
		20 Name and address of passes who	completed source of death ///-	m 00-1 1	Tuna Brist)	798	120			18/99			
		S.I. ALI 506			Type, Print)  UR Ed	astr	Ju MI	2 161	1				
St	ate	31. Dete filed (Month, Day, Year)	Registrar's Sign	ature		-10		-(100	,			^ =	
Regist		NOV - 8 1999	Registrar's Sign	19.	popula	61							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** NOVEMBER 7, 1999 1830 PARDOE GLADYS VIOLA /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Undar 1 Year If Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth OCL. 99, 1921 **Funeral** 9. Birthplace (State or Foreign 1□ M 2□√F 78 Florida 263 12 1465 Yrs. Director Usual Rasidance of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show traumatic event, the Medical Exantrer must be notified at Maryland Calvert Lusby Director 1 Yes 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 9766 H.G. Trueman Rd. 20657 United States 238 nit. Pages 1 and 2 should be filed within 72 hours after death vertinent of Health and Mentel Hyglene. ortant: If item 72 Is marked other than "natural; or items 234 injury or other traumatic event, the Medical Esperies mail Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Tas 2 No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Marriad 2 Marriad Baltimore, Maryland 21215-0020 white 1 ☐ Yas 2 No Specify: þ 3€ Widowed 4 Divorced Yaar or Datas Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) owner/prorietor grocery store 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Granville Green Eva Matteson 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Geraldine Melvin- daughter same as #10 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c, Location - City or Town, Steta 1 Burial 2 Cramation 3 Ramoval from State permit. Page Depertment of Important: If any injury or once. Middleham Chapel - Nov 10 1999 Lusby, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funaral Service Licensas 22. Nama end Addrass of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port REpublic MD 20676 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) SEPSIS Iweek Examiner Dua to (or as a consaquanca of): Examiner PNEUMONIA Attending Physician: The law requires thet the death certificate be executed attending physician and for use es the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last Dua to (or as a consequance of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) ed by the at detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CUPD, RENAL FAILURE Division of Vital Records, þ Completed 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? hes 2 20No certificate 1 ☐ Yas 1 ☐ Yas 2 No Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 1 Donpatiant 2 ER/Outpatient 3 DOA After this 27. Mannar of Death Medical Certification: 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural death 1 Yas 2 No i or Attendi efter death Director: A 2 Accident in by the 3 T Suicida 6 Couid not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida within 24 hours e To the Funeral C completely filled Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Cartifian Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, data and place, end due to the causa(s) (Check only and mannar steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/8/99 D 36969 30. Name end addrass of parson who complated causa of daath (Itam 23a) (Type, Print) M.D. Prince Frederick, Maryland 20678 Scaria Mathew. 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State NOV 1 0 1999 >

Registrar

State of Maryland / Department of Health and Mental Hygiene 99 36340

				Certificat	e of	Death		Reg. I	No.		30040
	1. Decedent's Name (First, Middle	, Last)						te of Death		Van-	3. Time of Death
Physician	Rosalie Anna	Marie Rob	erts						Day L 19	Year 99	12:15am
/Medical Examiner	4a Facility Name (If not institution				4	b. City, Tow	m, or Location		4c. County	-	12000
LAdillile	Westminster	Nursing &	Conval	escent	Cti	r We	stmin	ster	Car	rol	1
Funeral	5. Social Security Number		ge (In yrs. lest bir	thday) If Unde	r 1 Year	if Under 2		te of Birth onth, Dey, Yea			place (Stete or Foreign ntry)
Director	215-22-5930	1□ M 2以 F	97	Yrs. Months	Days	Hours		an 30	1902		MD
	Usual Residence of Decedent							JII			
thygiene.  thygiene.  thygiene.  thy the Medical Evaniner must be notified at a Completed by Funeral Director	10a. State 10b. County		10c. City, Tow	n or Location						1	0d. inside City Limits
io io	MD Car	roll	Westm	inster							1 ☐ Yes 2 ☑ No
or 28a-f a	10e. Street and Number			10f. Zij	Code			10g.	Citizen of W	hat Coun	ntry?
S 0		on Road			211	57			USA		
al', or items 23a or 28a-f show Evantrier must be notified at by Funeral Director	11, Maritai Status	12. Was Decedent	Ever in U,S.	13. Was Dece	dent of H	ispanic Orig	In? (Specify Y	es or No-			an Indian,
5 E	1 Never Married 2 Marri	Armed Forces					Puèrto Rican,	e(C.)		k, White,	
b v	3€ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Yes	21 <b>3[</b> No	Specify:			Specify.	Wh:	ite
	15. Decedent	's Education	16a.	Decedent's Usu	al Occup	ation		16b	Kind of Bu	siness/Inc	dustry
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To Be Comp	12	Conege (1-40)	54)	Homem	akei	r			wn H	ome	
Be C		Last)				18. Mother	's Name (First	, Middle, Maid	len Sumem	ө)	
To B	John Hagedo	) 20 m				Λ	Thomps	on			
-	19a. Informant's Name/Relations		196	. Mailing Addres	s (Street				y or Town,	Stete, Zip	Code)
traction of	Craig Giles/		11	21 Sin	ger	Driv	е				
other t	20a. Method of Disposition	Jranuson	20b. Place	stmins	ter me of	, MD	2115	20c.	Location -	City or To	own, State
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any injury once.	4 Donation 5 Other (Sp		Park	wood C			11/:				re, MD
50	21. Signature of Funesal Service I	Joensey	/	Pritt	s F1	ss of Facility Lnera	1 Home	e and	Chap	el	
	1. K.C.	1-	7				n Rd I				MD 21157
	23a. Part1. Enter the decision, or shock, or hear the List	complications that cause	the death. Do	not enter the mo	de of dylr	ng, such as o	cardiac or resp	iratory arrest,			Approximate Interval Between
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lical	Immediate Cause (Final disease or condition	a ASC	VD							1	10 m
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rector, pe	25. Was case referred to medical					26. Place	of Death (Che	ck only one)			
		Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatient 3 D	OA Oth	ner: 4 Nu	rsing Home 5	Residence	e 6 □Oth	er (Specia	fy)
	27. Manner of Death	28a. Date of Inj			28c. Injui Wor			escribe how i			
ed in by the funera Certification:	1 Avatural 5 Pendin investig		J ( Gal)	Injury M		Yes 2 1	No				
d in by the fur ertification	3 Suicide 6 Could r	and Zoe, Placa of In	jury - At home, fa	arm, street, factor	ry, office					er or Rure	el Route Number,
din	4 Homicide	building, e	fc. (Specify)				C	ity or Town, S	rere)		
		Physicien: To the best	of my knowledge	e, death occurred	et the tir	me, date end	d place, and du	e to the caus	e(s) and ma	nner es s	stated.
pletely fii edical	(Check only 2 Medical I	xaminer: On the basis of	of examinetion an	d/or investigation	n, in my o	pinion, deat	h occurred at t	he time, date	and place,	end due t	to the cause(s)
completely filled in the Medical Certi	29b. Signature and title of cartifier			29	c. Licens	e number		29d.	Date signer	d (Month,	Day, Year)
8	1010	10-	140	- W	7 -		147		. / ,	-	
	John h	molation	140		DA	1349	15	/	1/1/	79	
	30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)	n	,	1	_ ^	*	1-	/ .
	John mid	an mo	688 1	room 1	14.04	L, L	vist	mus	ch	n	1 21157
State	31. Da e liled (Month, Dey, Yeer)		rar's Signature	6	1	-					,
Registrar	NOV 0 2	1999	-	P. A	oou	6					

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State of Maryland / Department of Health and Mental Hygiene

36341 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month November 3 1999 **Physician** Mary Valedia Reed 9:45 Am /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Fairhaven Health Center Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) 5. Sociel Security Number Birthplace (State or Foreign Country) Funerai 094-09-4286 1□ M 2X F Months Director Feb 2 1910 Pa. Usuel Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygione. Important: if Itam 27 is marked other than "naturel", or items 23a or 28a-f show eny Injury or other traumatic event, the Madical Expriser must be notified at 10d. Inside City Limits Md Carroll Sykesville Director 1 XYes 2 No 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7200 Third Avenue 21784 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Aq 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) teacher education +8 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John C. Reed Lizzie Kershner 19e. Informent's Neme/Relationship (Type, Print)
Alice Reed Whittle (sister) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3922 Classen Blvd. Oklahoma City, OK 73118 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State All County Cremation 11-4-99 Sykesville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licensee Dage Haight Herbert P.O. Box 195 Sykesville, Md 21784 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Cerebrovoscular 2 Weeks diseese or condition resulting in death) Examiner Examiner sician and buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760. ettending physician for use es the burie Physiclan/Medical Due to (or es e consequence of) been signed by the should be detached Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? t Yes 2 No 3 Probably 4 Unknown rneumonia þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Mursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 0 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homlelde 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) Medical 29a, Certifier end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) November 3, 1999 30. Name end address of person wito completed cause of deeth (Item 23a) (Type, Print) Eldershun, MD. mez 1645 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State NOV 0 3 1999 Registrar

when the shower

SCOOL STORY

#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Death 3. Time of Death Day Year **Physician** Month ARCHIE RANTZ SR. W. 5,1999 1828 November /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO H Linder 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 11 12 35 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 10 M 20 F Hours Director 230-42-7386 Virginia Usual Residence of Decedent death with the Meryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Accomack Withams Virginia 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 7413 Neil Parker Road 23488 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working Olive. DO NOT use refired) of the Purify Machinest/mechanic 16b. Kind of Business/Industry College (1-4or 5+) Industrial 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Jesse W. Rantz Violet Burton 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7413 Neil Parker Rd--Withams VA Myra J. Rantz, wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 11-10-99 Chincoteague Island Crematorium 22. Name and Address of Fecility Fox Funeral Home 21. Signature of Funeral Service Licensee P O Box 278 Temperanceville VA 23442 Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Batween Onset end Deeth **Physician** /Medical Immediate Cause (Final diseesa or condition rasulting in death) Examiner Examiner thet the death certificeta be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated evants rasulting in deeth) Lest Box 68760 TOX Physician/Medical Due to (or es e consequence of): the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 2 No 3 Probably 4 Unknown should be det Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutorsy 1 Yes 2 No 2 No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical axaminar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 1 Naturel 5 Pending investigation death. 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and mannar as stated. | Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar steted. 29e. Cartifian Medical To the 29b. Signeture end title of c 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

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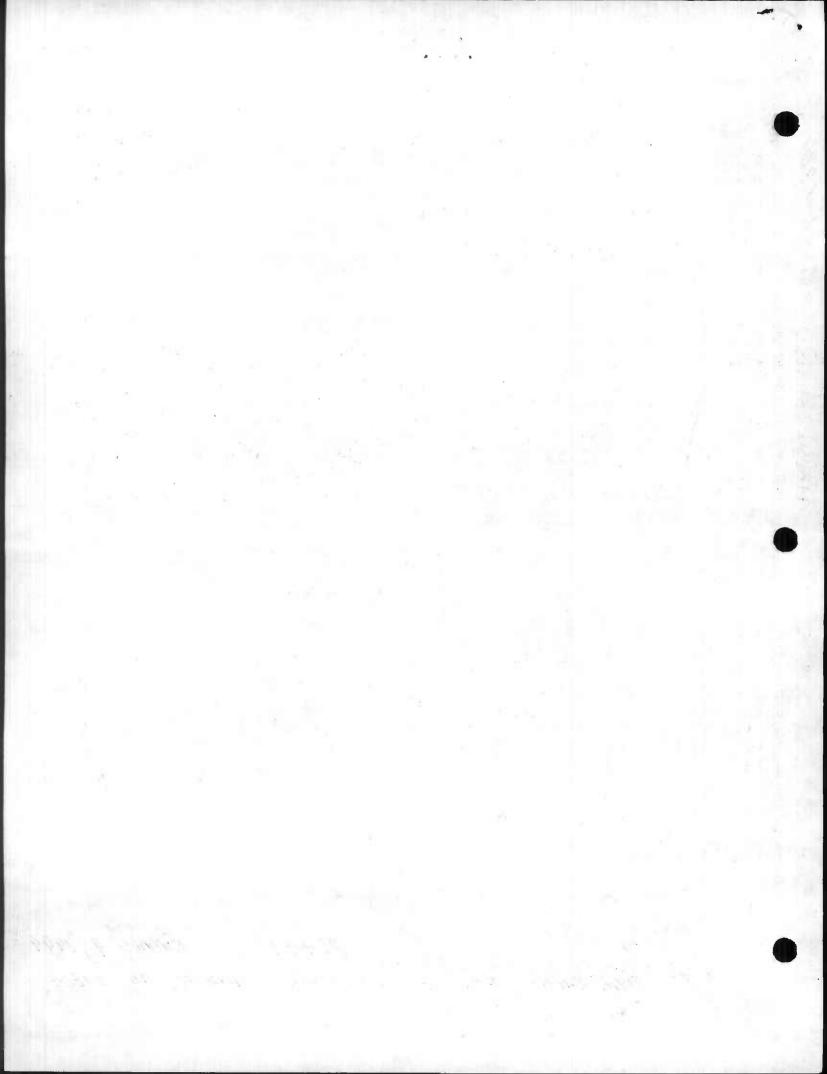
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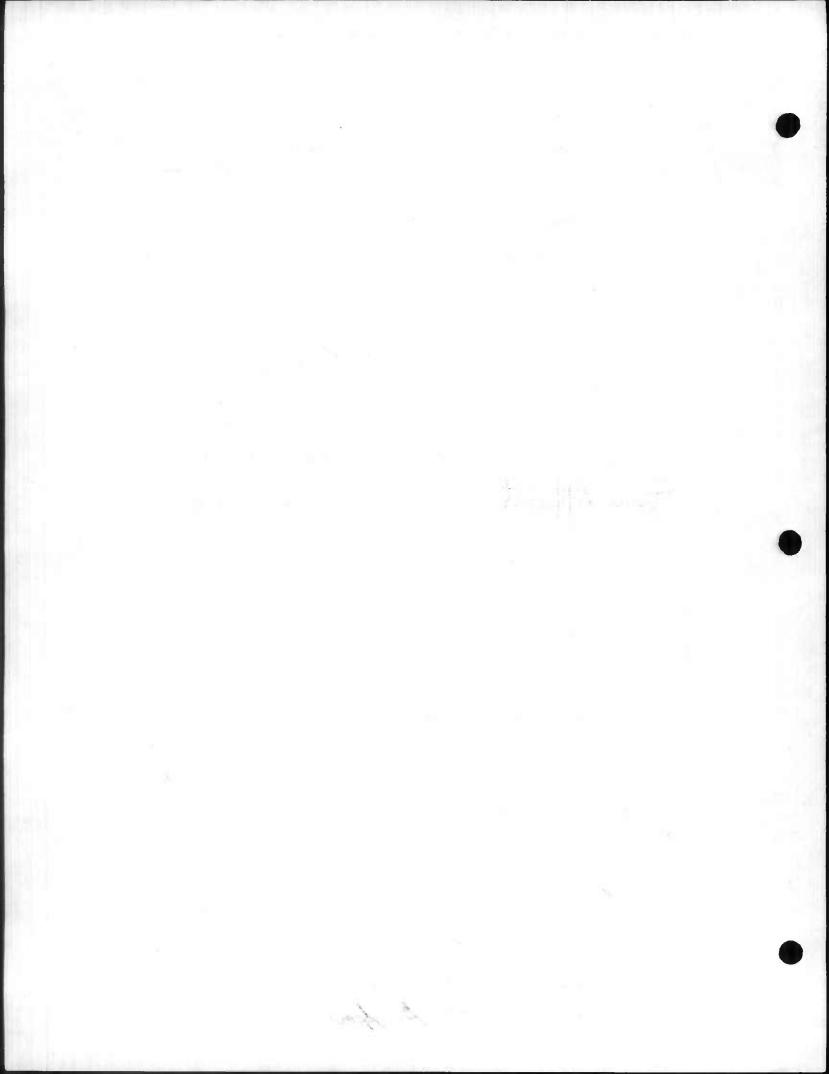
32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene Q Q

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	Physici /Medic			ICE					Month OCTOBE	Day	Year	3:27 PM				
	Examir		4a. Facility Nama (If not institution, give	a street end number)				4b. City, Town, or L	ocation of Death	4c. County						
	Funeral		MEMORIAL HOSPITA  5. Social Security Number   6. Se		yrs. lest birth	Month	lar 1 Yaar		8. Date of Birth Month, Day	1927	ANY 9. Birthplac MA Country	ce (Stete or Foreign				
٠.	Director		Usual Residence of Decedent	A /2					FEB 9,	4337	PIAKTLE	AND				
	Meryland f show	tor	10a. State 10b. County  MARYLAND ALLEGAR		c. City, Town	or Location BERLAN	D				10d	I. Inside City Limits  1 ☐ Yes 2 ☑ No				
	r 28a	Director	10e. Street and Number	11	0011		Zip Code			10g. Citizen of						
	th with	ai D	11808 EASTMAN ROA	AD N.E.				21502		U.S.A.						
020	2 should be filed within 72 hours after death with the Meryland and Mental Hygiane. Is marked other than "natural", or items 23s or 28s-f show raumatic event, the Medical Exprends must be notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: US	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						ca - American ck, White, etc	2.				
Baltimore, Maryiand 21215-0020		Completed	15. Decedent's E. (Specify only highest green Elementary/Secondery (0-12)	ducation ide completed) College (1-4or 5+)	Decedent's Us Give kind of v life. DO NOT		pation I during most of won ad)	king	16b. Kind of B							
d 2	filed y Hygia other t	e Co	17. Fathar's Nama (First, Middla, Lest,	ne)	LION											
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lan	and No.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Cod													
nore, N	permit. Pegas 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any Injury or other traumatic evonce.			20c. Location	MARYLAND 21502 on - City or Town, State BERLAND MD.											
Baltin	permit. P Departme Important any Injury pnce.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funaral Service Licensae  22. Name and Address of Facility  MERRITT—ADAMS FUNERAL HOME P.A.													
			23a. Part1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each tine.  Approximata intervat Between													
	Physician /Medical Examiner  paralliransit	Examiner	Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	b	to (or as a co							DAYS				
. Box 68760,	ificata be g physicia as tha bur	Physician/Medical E	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other algniffcant conditions c	cDualt	23h Dfd t	obacco usa co	ntribute to th	ne cause of death								
8, P.O.	s that tha de gned by the a e datached	by Phys	PERFORATED INTRA-		_		, saudo g			res 2□ No	3 ☐ Probat	1.4				
28-0078 Records,	Tha law requires that tha death cart at has bean signed by the attendin paga 2 should be datached for use	Completed !	MULTIPLE MYELOMA						24a. Was a perfor	an autopsy med?	availa	autopsy findings able prior to eletion of cause eth?				
-28		Con							1□ Y	es 2 No	1 🗆 Y	res 2□ No				
217-: Vital	cartific	Be	25. Was case referred to medical axaminer?	Hospital:			Ot	26. Plece of Dee								
o	Phys r this aral di	7: To	1 ☐ Yes 2 No 27. Manper of Death	28a. Date of Injury (Month, Dey Yaa	2 ☐ ER/Outp 28b. Tin		28c. Inju	4 Li Nuising H	ome 5 Rasid							
RICE	itending Physidaath. ctor: After this c y the funeral dir	atioi	1 Natural 5 ☐ Pending 2 ☐ Accident invastigation		(r) Inji	ury M		ork? ]Yes 2□No								
>	To the Hospital or Attending Physician: within 24 hours lefar death. To the Funeral Director: After this cartification and the funeral director with the funeral director.	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injury - A building, atc. (Sp	At home, fern pecify)	n, street, facto	ory, office		28f. Location (S City or Tow	treet end Numb n, State)	ber or Rural R	ioute Number,				
LEONARD Div	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, onination end/	death occurre or investigation	ed at the ti on, in my	ime, dete end ptace, opinion, death occur	and due to the or red at the time, o	ause(s) and ma late and place,	anner as state and due to th	ed. e cause(s)				
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	TRAS		30. Name and eddress of person who SIINTI. GIIPTA M D	and the second			D.T. ~	0.00	TDT 4355	0150	0 01	T 101				
	,		SUNIL GUPTA M.D., 31. Date filed (Month, Day, Year)	ACTINOON HET	GUID I	TEDICAL	- RTT	າG., CUMB∃	KLAND,	MD 2150	Z_SUIT	$E_{-}101$				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month **Physician** Robinette Charles NOVEMBER 5, 1999 12:30 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 5, 1924 Birthplace (State or Foreign Country)
 MD 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 74 Yrs. 218-12-5545 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show ms 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12905 Winchester Road SW 21502 USA Funeral 12. Wes Decedent Ever in U,S. Amped Forces? 1 Mayes 2 □ No If Yes, Give Yeer or Detes: WW II Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) electrical maint. Artmor Plastics Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Depertment of Health and Mental important: If them 27 is marked or any injury or other trsumatic events. George A. Robinette Ollie (Orndoff) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12905 Winchester Rd; Cumberland MD 21502 19e. Informent's Neme/Reletionship (Type, Print)
Mary B. Robinette Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Kuriel 2 Cremetion 3 Removal from State 4 ☐ Donetlon 5 ☐ Other (Specify) Sunset Memorial Park 11/08 Cumberland, MD 21. Signature of Funeral Service Licensee 22 Scarber 19 Fartuneral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Cardine 40 hours Examiner Examiner The law requires that the deeth certificate be executed and Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting In death) Lest Due to (or es a consequence of): Box 68760. ed by the attending physician detached for use es the buria Physician/Medical the Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. Cardio-pulmonary 1 Yes 2 No 3 Probably 4 Winknown P 8 24b. Were eutopsy tindings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed left basal ganglia infarct. hes 25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, to Be 26. Place of Death (Check only one) 1☐ Yes 2☐No Hospitel: 157 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 295. Signeture end title of certified D21244 NOVEMBER 6, 1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) FROSTBURG MD. 21532 TAN M.D. FROSTURG PLAZA **JESUS** 31. Dete liled (Month, Day, Year) 32 Registrar's Signeture State Registra

ton a

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Joseph Robertson November 7. 1999 09:55 AM /Medical 4c. County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cumberland
If Under 24 Hrs. Memorial Hospital & Medical Center Allegany 8. Date of Birth (Month, Day Year) ADT 24, 1914 Il Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 6 Sex **Funeral** Months Days Hours 1GM 2□ F 217-10-7003 85 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ahow r than "natural", or items 23s or 28s-f ahor the Wedesi Essember must be notified at 1☐Yes 2☐No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Potomac Street 21502 IISA Funeral 12. Was Decedent Ever in U.S. Acqued Forces? 1 B Yes 2 □ No If Yes, Give Year or Detes: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene. Ither than "natural", or field 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Textile retired coning dept. Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Haalth end Mentel I int: if Item 27 is marked of George Robertson Maude (Harding) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 Potomac Street; Cumberland MD 21502 19a. Informant's Name/Reletionship (Type, Print) Florence I. Robertson Potomac Street; Cumberland other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Xuriel 2 ☐ Cremation 3 ☐ Removal from State = 6 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 11/10 Cumberland, MD 21. Signatu 22 Scarber 1 1 Fartuneral Home P.A. Cumberland, Maryland cations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final 3 WEEKS disease or conditio resulting in death) Pneumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner 3 WEEKS Adult respiratory distress syndrome The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760. physicien that initiated events resulting in death) Last the Due to (or as a consequence of) 950 signed by the atter Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? O 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 0 Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? hes 1 ☐ Yes 2 ☐ No certificate director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 N Inpatient 2 ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day Year) funeral To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation latural 1 Tyes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a. Certifier rer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie in 8 1999 D 36766 November 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) Mis Poonai. M.D. 920 National Highway, LaVale, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

9 1999

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Robertson

Joseph

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month 1999 Nov. 08. 3:04AM JAMES JOSEPH SMITH, SR. 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death La Plata Civista Medical Center Charles If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Yaar) 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) 1X M 2□ F Months Days Yrs. 75 June 27, 1924 Maryland 217-14-7006 Usual Rasidence of Decedan 10c. City, Town or Location 10a Stata 10b. County 10d. Insida City Limits 1 ☐ Yas 2 No MD Charles Newburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 14825 Rock Point Road 20664 USA 12. Was Dacedant Evar in U,S. Armed Forcas? X□ Yas 2 □ No 1943 – If Yas, Giva Yaar or Datas: 1946 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 Navar Marriad Married 1 ☐ Yes 2 X No Specify Specify:White 3 ☐ Widowad 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Electric Electrician 18. Mothar's Nama (First, Middla, Meidan Sumeme) 17. Fathar's Nama (First, Middla, Last) Miriam Everett Smith Elizabeth Linton Smith 19b. Mailing Addrass (Street and Numbar or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Intermant's Neme/Reletionship (Type, Print) 14825 Rock Point Rd. Newburg, MD 20664 Doris Smith/Wife 20b. Place of Disposition (Nama of camatary, crametory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Trinity Memorial Gar. 11/11/99 Waldorf, MD 21. Sign yure of Funaral Sarvice Licansaa AREHART-ECHOLS FUNERAL HOME, P.A. M00945 P.O. BOX 567 LA PLATA, MD 20646 Approximata Interval Between Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haert tailure. List only one cause on each line. Immadiate Cause (Final diseasa or condition resulting in deeth) ATURE KONEDN Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? completion of causa of daath? 250 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was casa ratarred to medical axaminar? 26. Pleca of Deeth (Check only ona) Hospital → Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner The law requires that the death certificate be executed

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/Medical

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Examiner Physician/Medical by Completed funeral director. Be Certification: To efter deetl Director:

After

Division of Vital Records, P.O. Box 68760.

Attending Physician:

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27. Manpar of Death 1 Netural 2 ☐ Accidant 5 Pending

3 Suicida 4 Homicida 28e. Data of Injury (Month, Day Year)

invastigation 6 ☐ Could not be detarmined

28a. Place of Injury - At homa, tarm, straat, tactory, office building, atc. (Specify)

28t. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Certifying Physician: To the bast of my knowledge, death occurred at the time, date end piece, end due to the causa(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29c. Licansa number

29b. Signajora and titla of certifiar

D-20629

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

30. Name and addrass of person wire completed cause of death (Itam 23a) (Typa, Print)

George H. Wathen, MD 11345 Pembrooke Square, Suite 103, Waldorf, Maryland 20603

State Registrar 31. Dete tiled (Month, Day, Year) NOV 1 0 1999

32. Ragistrar's Signatura Tener

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State of Maryland / Department of Health and Mental Hygiene 99 36347 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dey Physician STERLING NOVEMBER 5 1999 ROBERT WILLIAM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER tf Under 24 Hrs. 8. Date of Birth (Month, Day; Year) If Under 1 Year 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 63 Director 229-46-0355 VIRGINIA Usual Residence of Deceden 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits of a should be filled within 72 hours after death with the Manyler. It and Mental hygiens.
It marked other then "natural", or frems 23e or 28e-f show them the months of the Mental Bandher. 1 ☐ Yes 2 No Directo 20025 Metompkin Rd., Parksley Virginia Accomack County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23421 20025 Metompkin Rd. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🖾 Married 1 Yes 2 No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE OWNER/OPERATOR 11 permit. Pages 1 and 2 should be file Department of Health and Mental Hy importants if then 37 is marked oth any Injury or other treumatic event obbs. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 8 Paul J. Sterling Doris Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Sterling - SPOUSE 20025 Metompkin Rd., Parksley Virginia 23421
Disposition (Name of Date 200. Location - City or Town, State altimore. 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal trom State Salisbury Crematory 11/6/99 Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WILLIAMS-PARKSLEY FUNERAL HOME 21. Signature of Fugural Service Licensee 25046 PARKSLEY RD., PARKSLEY, VA. 23421 23a Pol. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Imuzisible Shock Examiner Due to (or as a consequence of) Robobly 20 to ischemic Boux Examin physicien end the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequance of): Box 68760, an/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Rhsumabid athrita diabstes mellitus by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 10 12 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 284. Data of tnjury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 DNaturat 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident star death Director: A d in by the f 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Place of tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Hospital or A
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 Funeral Directions districtly filled in b 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-5.99 D76612 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Rd, Suite 7. Salisbury, MD 2,801

Registrar

31. Data filed (Month, Day, Year)

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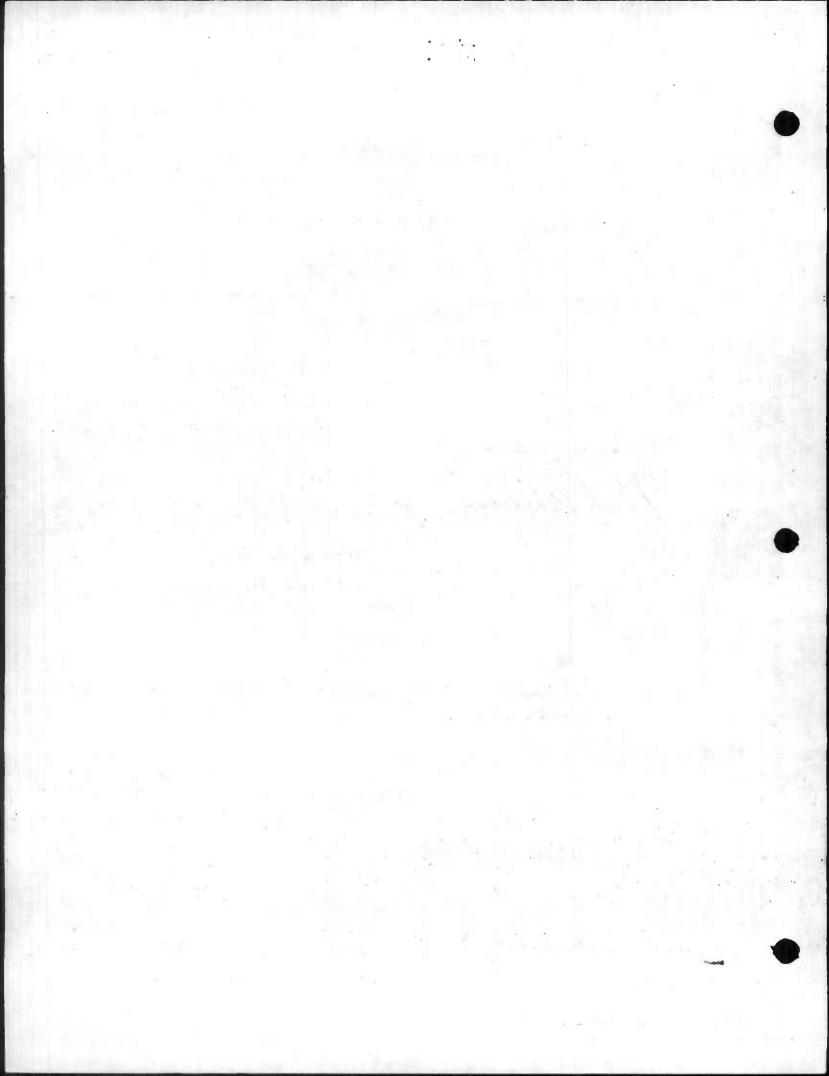
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32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene q q 36348 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth Dey 1999 **Physician** NOV. 6, 4:55 am L.E.A.H. LANE STALEY /Medical 4a. Fecility Neme (If not institution, give street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cambridge Dorchester 604-3 Water St. If Under 1 Yaar If Undar 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) 9. Birthplece (State or Formatty) Mar. 31, 1917 Maryland 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foraign **Funeral** Months 1□ M 2XF Yrs 82 Director 220-12-4877 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ¹X Yas 2 □ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 604-3 Water St. 21613 Funeral 12. Was Decedant Evar in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Marital Status 1 ☐ Yes 2 🗓 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired)
Business Manager and Partner 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Industrial Belting 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important it flow 27 is marked other any injury or other transfeed other. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Leah Robinson Leroy Lane 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 604-3 Water St., Cambridge, MD 21613 Barbara S. Field/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 Cremation 3 ☐ Removel from Stete Cambridge Crematory 11-8-99 Cambridge, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral,S 22. Name and Address of Fecility Curran-Bromwell Funeral Home, Emmuel 308 High St., Cambridge, MD 21613 23a. Pert / Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. It only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Respiratory Failure 3 weeks Examine Dua to (or as a consequance of): Examiner 1 month Acute exacerbation, chronic obstructive lung physician and the burial-transit disease Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequence of) Box 68760. Chronic obstructive pulmonary disease that the daath certificate be Physician/Medical 10 years thet initiated events Dua to (or es e consequence of): rasulting in deeth) Lest Se USB 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? the detached signed by t 1 Yes 2 No 3 Probably 4 Unknown Atrial fibrillation ð The law requires 24b. Were eutopsy findings evelleble prior to completion of causa of deeth? 24a. Wes en eutopsy performed? Completed peen Lung Cancer page 2 s cartificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: after death. director, Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? exeminer? Hospital: Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 2 Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide hin 24 hours aft the Funeral Dli nplataly filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at tha time, dete end place, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner stated. 29a. Cartifier Medical (Check only one) within 2 To the the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifie 0 D 11284 Nov. 8, 1999 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

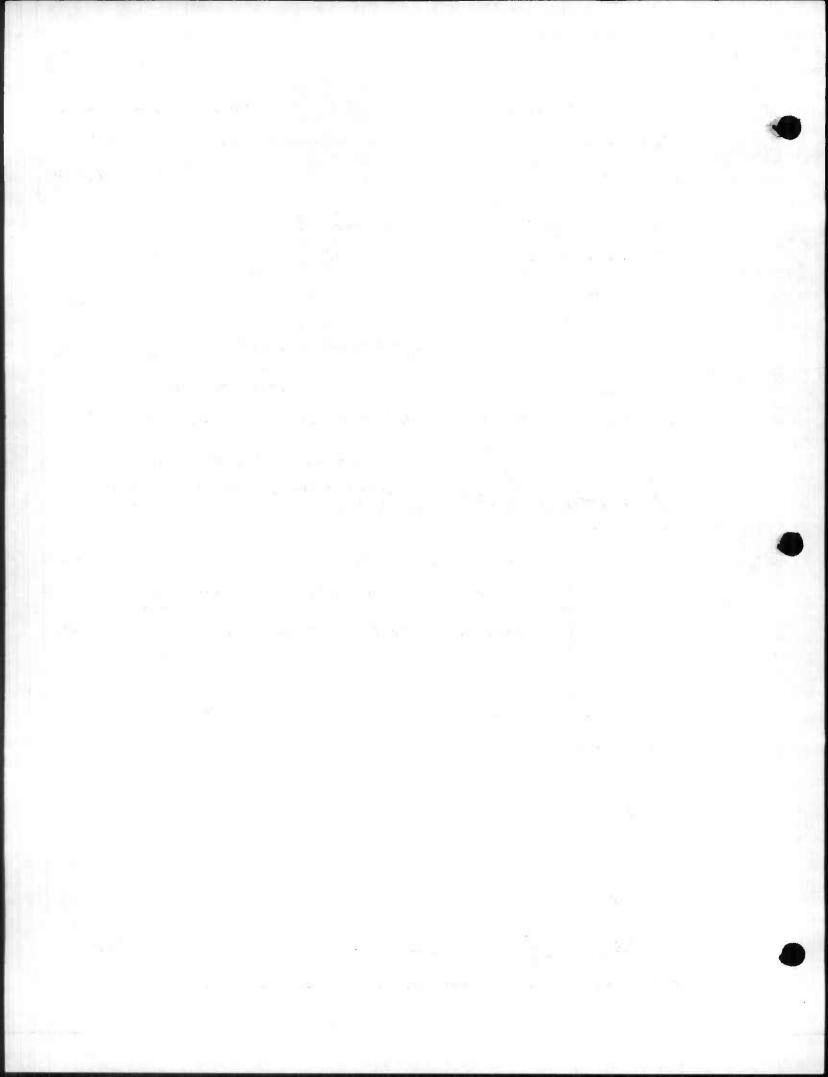
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32. Registrar's Signature

A.R. Wilke, M.D.,

B. Sparks

400 Maryland Ave., Cambridge, MD 21613



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 03 anlel :29 P.M. oung drec 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) 63 Baltimore If Under 24 Hrs. 8. Date of B. Hours Min. (Month, D. 5 Pring Circle Baltimore 0 Mill If Under 1 Year Months Days 5. Social Security Number Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, 9. Birthplaca (State or Foreign Country) 220-01-1 M 2 F Days Jan, 16, 1909 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Dorchester ambrida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 re 1000 16 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20 No r Yes, Give Year or Dates: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Community Support Elementery/Secondery (0-12) College (1-4or 5+) and parent Agency 18. Mother's Name (First, Middle, Maiden Surname) Foster Grandparent 17. Father's Name (First, Middle, Last) Lhoch Nabel Bank. ouno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 66345pring Mill Circle Baltimore, MD. 21207 ace of Disposition (Name of Date 20c. Location - City or Town, State handler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State Cenetery 11/08/99 Salem, Maryland +. Pleasant 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Fune HOME, PA Funera 510 Washington St. MD, 21613 ambridge 23a. Purty Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death mejastatic Adenocai Immediate Ceuse (Final disease or condition resulting In death) Due to (or as a consequence of): elepicic Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as donsequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Saughters Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA rendence

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Division of Vital Records, P.O. Box 68760

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Completed page 2 funeral director, Be 2 Certification: filled in by

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Attending Physician:

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Hospital 24 hours e Funeral C

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1□Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined 28e. Date of Injury (Month, Dev Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Natural 2 ☐ Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certification

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Austz. SHMED

31. Date filed (Month, Day, Year) NOV 0 9 1999

street Cambridge, MD 21613

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician LARRY** ARTHUR SMITH 12:30 p.m November 2, 1999 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Memorial Hospital Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Yrs. Director 217-56-8533 20,1952 Maryland Usual Residence of Decedent tha Merylend 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f show Director 1 X Yes 2 □ No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours aftar death with 15 North Church Street 26726 USA Funeral Herna ? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. The Medical Examiner 1 Never Married 2 Married 21215-0020 ò Completed by 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced "natural". White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiane. Eyeglass/Optical Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Manufacturing i. Pagas 1 and 2 should be filed w tmant of Health and Mantel Hygian tant: If them 27 Is marked other th jury or other treumatic event, In Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be S. Arthur Smith. Sr. Frances L. Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur S. Smith, Sr./Father 15 North Church Street Keyser, WV 26726 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov. 5 permit. Page Department of Important: If ony Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Queen's Point Cemetery 1999 Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home Trian of 85 S. Main Street 26726 Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediete Cause (Final disease or condition resulting in death) Sepsis 72 hours Examiner Due to (or as a consequence of): Examiner Advanced Large Cell Lymphoma Sept. 1999 The law requires that the death cartificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last end Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medicai Due to (or as a consequence of) for usa as tha ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to be datach 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? director, paga 2 should Completed 24a. Wes an autopsy Aftar this cartificeta has bean 1 Yes 2 No 1 ☐ Yes 2 ☐ No Larry Smith 21 Division of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this cartifice completely filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 En/Outpatient 3 DOA 2 No 2 1 Yes Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural
2 Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 3,1999 D0023371

Zaman, Johnson Heights, 625 Kent Avenue, Suite 102, Cumberland, MD 21502

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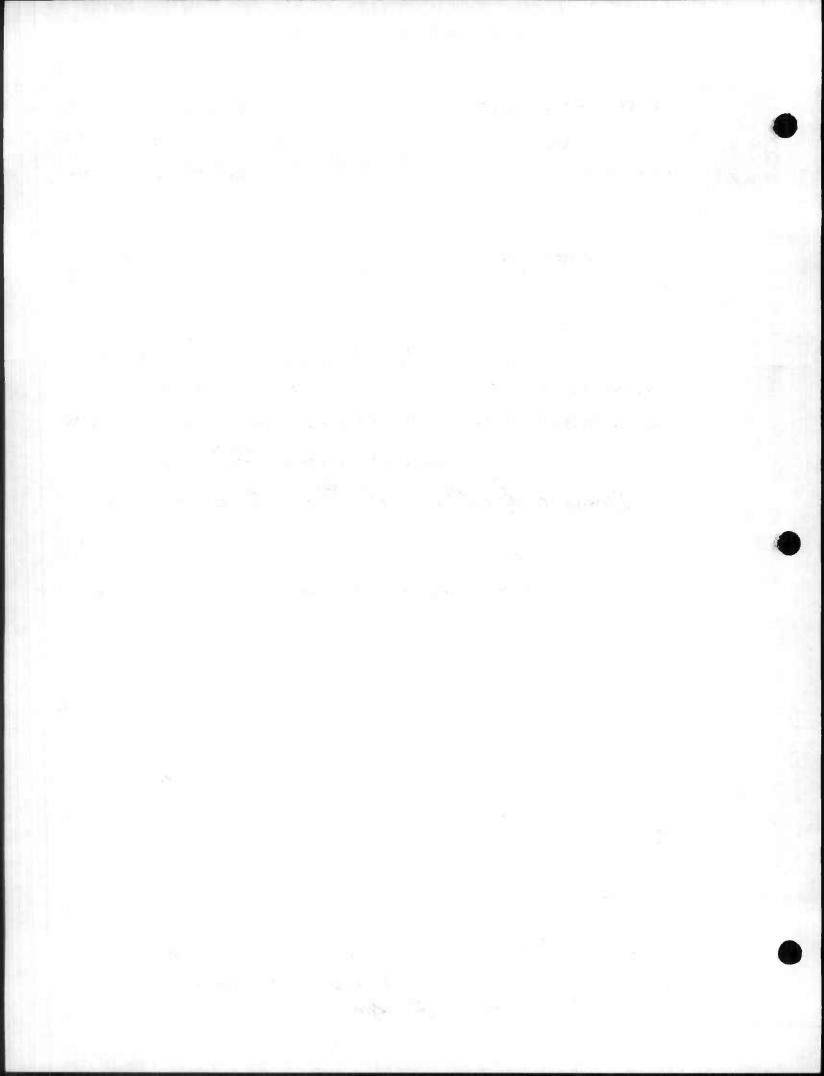
31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

**DHMH 16 Rev 6/95** 

217-56-8533



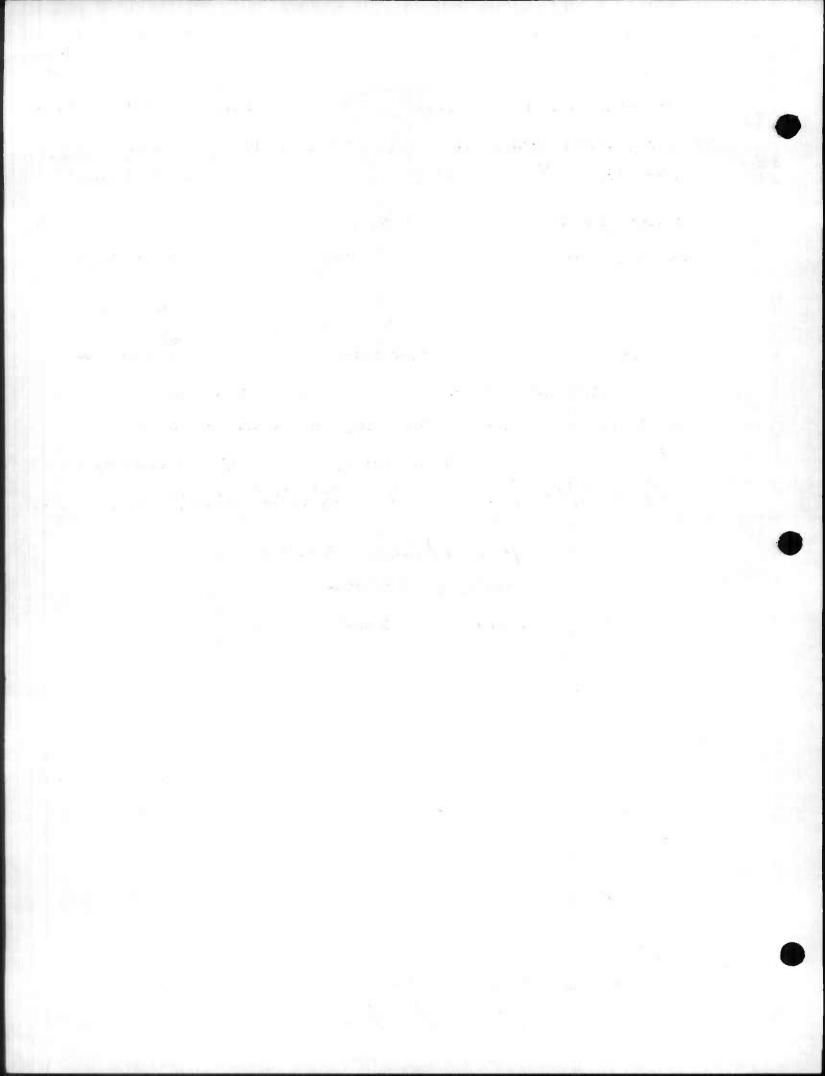
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Dey 1999 Year Walter Martin Shaffer, Jr. 3, Nov. 6:12 PM /Medical 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Annapolis A

If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey. Year) Anne Arundel Medical Center Anne Arundel 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (Steta or Foraign Country) **Funeral** 100MM 2□ F Months Yrs. Director 217-36-1655 60 October 28, 1939 Maryland Usuel Residence of Deceden the Meryland 10a Stete 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26012 Garey Road 21629 United States Funeral 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Stetus 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Detes: 1 Nevar Married 3 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 25 No Specify: by Specify: Caucasian 3 ☐ Widowad 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health end Mental Hygiene. int: If Item 27 Is marked other than " Farm Elamantary/Secondary (0-12) College (1-4or 5+) Owner/operator 12 HS Grad. Equipment Business 17. Fether's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Be Walter Martin Shaffer, Sr. Emily Louetta Hayman 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Jo Shaffer Wife 26012 Garey Road, Denton, Maryland 21629 other 1 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 0 1 Burial 2 Cramation 3 Removel from Stata permit. Pege Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 11/7/99 Denton, Maryland Denton Cemetery 21. Signature of Funerel Service Licensee 22. Nama end Address of Fecility Moore Funeral Home, P.A. oars 12 South Second Street, Denton, Md. 21629 23a. Pert1. Entar the disaase, or complications that caused tha deeth. Do not entar tha mode of dying, such es cardiac or respiratory arrast, shock, or heart feilura. List only ona causa on each line. Approximete interval Between **Physician** MYOCARDIAL INFARCTION /Medical Immediate Ceuse (Finel disaase or condition resulting in death) Examiner Dua to (or as e consequence of):
HYPER LIPIDEMIA

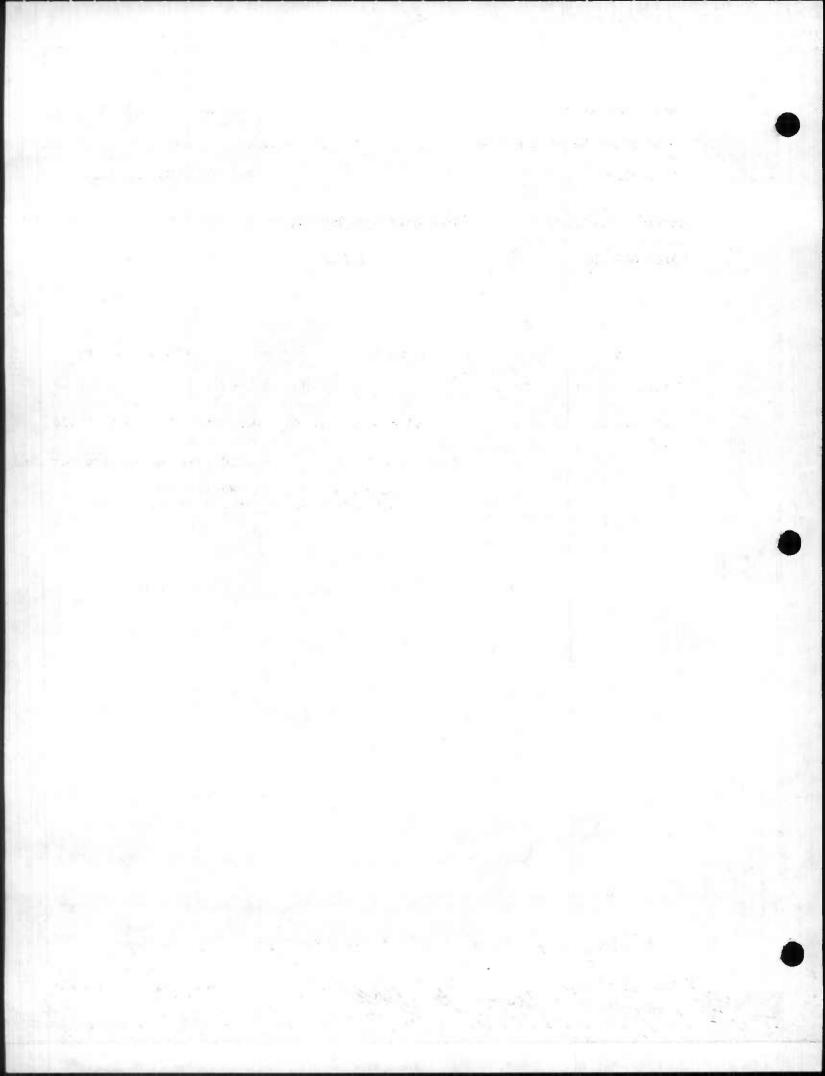
Due to (or es e consequence of): Examiner -transit The law requires that the death certificete be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest end Box 68760. physician Physician/Medical the P.0. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contributa to tha cause of death? signed by a 1 ☐ Yas 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed by 24a. Was en eutopsy performed? 24b. Wara autopsy findings availabla prior to compiation of causa of death? page 2 s 1 Yas 2 No sertificete 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this sertifice stely filled in by the funeral director; Be 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residance 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 1 Maturel 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, Steta) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Phyeiclan: To the best of my knowledga, daath occurred et the time, date end plece, end due to the causa(s) end mannar as steted.

| Medical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the causa(s) end manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. Licansa numbar 29d. Date signed (Month, Dey, Year) D0053815 Neme end eddrass of person who complated cause of deeth (Item 23e) (Type, Print) KORAH M. PULIMOOD, MD 5105, 5th AVE. DENTON, MD. 21629 31. Data filad (Month, Dey, Year) 32, Registrer's Signature State Registrar NOV - 5 1999



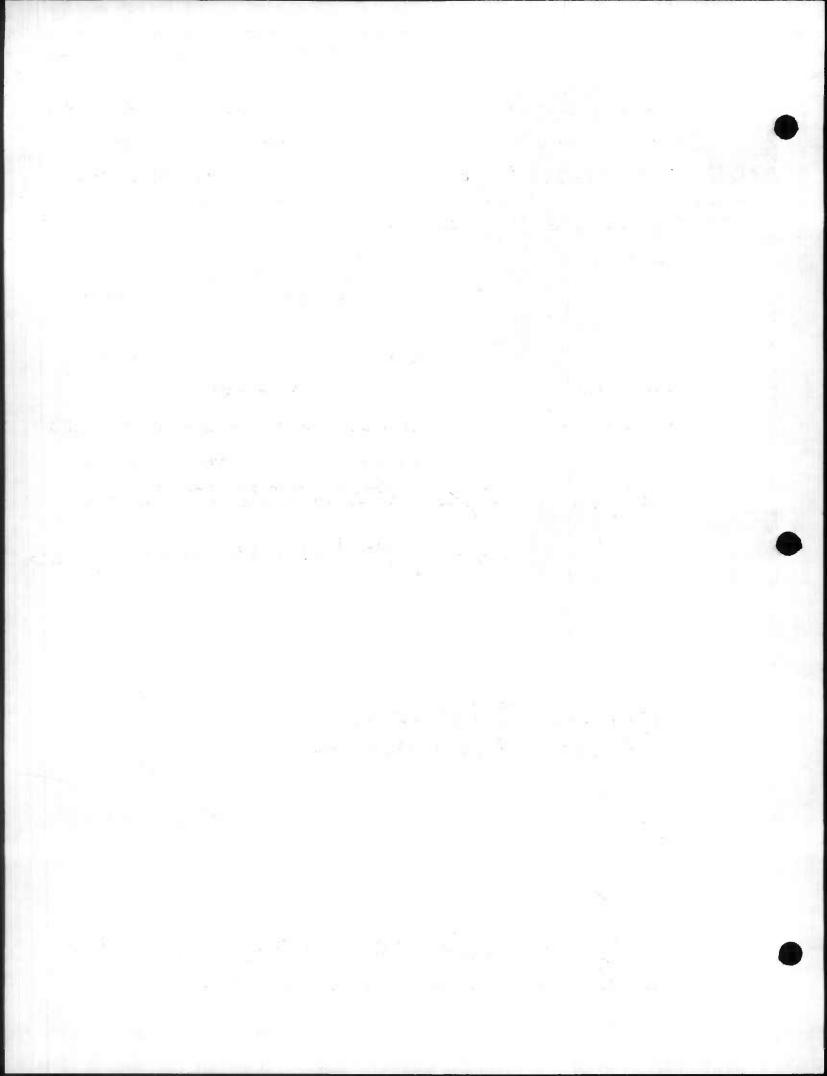
State of Maryland / Department of Health and Mental Hygiene 9 9

	_		Decedent's Neme (First, Middle, L.	nst)	_	Cenii	icate of	Death	2. Date of Dee	leg. No.	2.7	Time of Deeth	
ŀ	Physic		Edward K Steele	,					Month	Dey	Yeer		
	/Medi Exami		4a. Fecility Neme (If not institution, gi	ve streat and number)				4b. City, Town, or L	October ocation of Death	28 19 4c. County		5 AM	
6	LĄdiiii	IICI	Chestertown Nurs	ing & Reha	hilita	ation		Chesterto	67TD	Kent			
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. les	t birthday) If	Under 1 Year onths Deys	If Under 24 Hrs.	8. Date of Birth (Month, De)		9. Birthpleca (	Stata or Foreign	
	Director		219-03-2/95	1 <b>∑</b> M 2□F	94	Yrs.	onins Deys	Hours Min.	Feb 15,	1905	Country) Marylan	d	
	pur *		Usual Residence of Decadent  10e. State 10b. County		10c City 1	Town or Location	an .				10d In	eide City Limite	
	be filed within 72 hours efter death with the Manyland tiel Hyglene. Id other then "neturel", or Items 23e or 28e-1 show event, the Modical Examiner must be recurred.	25									10d. Inside City Limit:		
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				2.1							viiet Courtily t		
		Funeral	26186 Goldsboro I	12. Was Decedent	Ever in U,S.	13. Was	21636 Decedent of I		pecify Yes or No-	USA 14. Rac	a - American Ind	tien,	
020		þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			s, specify Cub Yes 2 🗓 No		Origin? (Specify Yes or No- ican, Puerto Rican, etc.)  2ify:  S		ck, White, etc.  white		
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation		16e. Decedent	s Usuel Occu	pation during most of work	kina	16b. Kind of Bu	of Business/Industry		
7	ILITIOTE, MATY IS  I. Peges 1 end 2 should Iment of Health end Mer Itant: If item 27 is marke Ijury or other treumatic	Completed	Elamantary/Secondary (0-12)	Collaga (1-4or 5	5+)	life. DO l	VOT usa retire	d)	ung				
			17. Fether's Name (First, Middle, Las	4)		mechan:	ĹĊ	40 Martinda Mari	- 151 - 4 Adi Atta		ufacturing		
and		Be C	Wilson K Steele	9				Mary E		Melden Sumam	10)		
2		P	19a. informant's Neme/Reletionship	(Tyne Print)		10h Mailing A	ddraee /Strae	reet end Number or Rural Routa Number, City or Town, Steta, Zip Code)				1	
			Elwyn Steele	Son		26186			Goldsbor			1636	
re,			20e. Method of Disposition			a of Dispositio			Dete		City or Town, SI		
Ë			1 Burial 2 □ Cremetion 3 [ 4 □ Donetion 5 □ Other (Speci			nsboro			et 30,19	00 Cre	anchara	,Marylar	
2			21. Signature of Funerel Service Lica		OLCC		me end Addre		50,15	)) GIC	CHSDOIC	, ital y Lai	
מ	Depariment of the part of the		1 At an	1 Fluid	(			Helfenbe:					
	5 5 60	Г	23a. Part1. Enter the disease, or con shock, or heart feilure. List only	plications that caused	the deeth.	Do not enter th	e mode of dyl	O Greensl	or respiretory er	ryland est,	Appro	oximete	
	Physician		Stock, of fleet fendie. List only								Onse	vel Between et and Death	
	/Medicai Examiner	disease or condition											
	Examinet	,	rasulting in death)	6.	Dua to (or e	s e consequen	ce of):		11.	1.5			
	bed sit	nine		b. Zever	re Aov	ticSten	osis i	AND Souve	Left Veni	trical D	ystuction	и	
	xecul end al-trar	xar	Sequentially list conditions, if eny, laading to immediate cause. Entar Underlying Causa (Disease or injury		Due to (or es	s e consequen	ca of):		1				
58/50,	icate be executed physician end s the burial-transit	edical Examiner	Cause. Entar Underlying Causa (Diseese or injury thet initieted events	C									
Q	ifficating phy	edi	resulting in daath) Lest		Due to (or es	e consequenc	ce of):						
DOX	anding use	In/M											
	es that the death cer igned by the ettendin be detached for use	by Physician/	Part II. Other significent conditions	contributing to death be	ut not resultir	na In the under	lving cause gi	ven in Part I.	23b. Did to	obacco use cor	ntribute to the c	ause of death?	
л Э	by the	Phys	10									4) Unknown	
	es the		Mitral Regurgatal	ion, must	pie M	ewcva	5, DV	n rype 11					
necords,	requir	Completed	Squarmons Cell Ct	OLip, D	owent	tia, O	foot_I	Schemic	24e. Wes e perfor	n eutopsy med?	24b. Were eut eveileble completio of deeth?	prior to on of cause	
-		Con							1 □ Y	es 2 No	1 ☐ Yes	2 No	
Altal	sicien: The law certificate hes t irector, page 2 s	Be	25. Wes case rafarred to medical examinar?	Manufact			1.	26. Place of Deel	h (Check only or	10)			
5	physic this c	7°	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie			DOA Ott	440 Nursing Ho	ome 5 Resid				
5	After After funer	lo	1 Naturel 5 ☐ Panding	28a. Dete of Injui (Month, Day	Year) 28	Bb. Time of Injury	28c. Inju	ryat rk?  Yes 2 □ No	28d. Describe h	ow injury occurr	ed		
DIVISION	deat ctor: y the	flca	2 ☐ Accidant Investigation 3 ☐ Suicida 6 ☐ Could not be determined.	000 Diago - ( )-1-	urv - At homa			1163 2 1140	28f. Location (S	traat and Numb	lumber or Rural Route Number,		
Ś	of or J	Certification:	4 ☐ Homicida determined	building, ato	(Specify)	.,, 511001,	,, 011100		City or Town	n, Stete)			
	hours hours merel y fille		29a. Certifier 1 Certifying Pt	ysician: To the best of	of my knowle	dge, deeth occ	urred et the til	me, dete end placa,	end due to the c	euse(s) end me	nnar as statad.		
	To the Hospital or Attending Physicien: Within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examone)	niner: On the basis of end menner sta	exemination	end/or Investig	gation, in my o	plnion, daath occur	red et the time, d	ata and placa, a	and dua to tha ca	ause(s)	
	To t To tl	Z	29b. Signature and title of certifier	0 00			29c. Licens				d (Month, Dey, Y		
			Mayoo	a will	)		D5	8996 Chester		185/01	49.		
T.		-	30. Name end eddress of parson who	completed cause of de	eeth (Item 23	Ba) (Type, Print	)	2/ /					
			Neil Studda	d, 100	BIP	ww S	to C	hester	town	, mel	. 216	20	
	Sta	ite	31. Dete filed (Month, Day Year)	Se 32 Regions	rs Signature	400	COS			,			



State of Maryland / Department of Health and Mental Hygiene Q Q

						Cei	rtificat	e of	Death		F	Reg. No.	9 0	033	J	
			1. Decedent's Neme (First, Midd	le, Last)							2. Date of Dee			3. Time of	Deeth	
	Physic		Elizabeth Marga	aret Smith							Month October	28,	Yeer 1999	2:00	AM	
1	/Medi Exami		4a. Fecility Neme (If not institution		ber)				4b. City, To	own, or Lo	ocation of Deeth		y of Deeth		1111	
	LAGIIII	IICI	11946 Greensbo	ro Rd					Green	shor	.0	Caro				
H	Funeval		5. Social Security Number		. Age (In yrs. lesi	t birthday)	If Under	1 Year			8. Date of Birtl (Month, De)			nlace (State o	r Foreign	
	Funeral Director		216-07-4533 Usual Residence of Decedent	1□M 2∏F	84							of Birth h, Dey, Year)  9. Birthplace (Stete or Foil Country)  15, 1915 Maryland				
	tend		10e. State 10b. County	1	10c. City, T	own or Lo	cation						1	10d. Inside Cit	y Limits	
	Very fish	0	V 1 1 0 1											1 🗆 Yes	2X No	
	the 28s	Director	Maryland Carol: 10e. Street end Number	Lne	Gree	nsboı	10f. Zip	Code				10g. Citizen of Whet Country?				
	with a or	ā					101. 210	0000				rog. Ottizen or	WHEL COU	illy r		
	a 23	Funeral	11946 Greensbo		fent Ever in U.S.	40.1	216:		ll'a carla O	1.1-0.40-		USA		I- #		
	her d	S	11. Marital Status	Armed Ford	ces?	13.	If Yes, spec	cify Cub	oen, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)	Ble	ck, White,	can Indien, etc.		
21215-0020	be filed within 72 hours efter death with the Meryland Ala Hygiene. d other than "natural", or Name 23s or 28s-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Man 3 Widowed 4 Divorced	If Vec Give			1□ Yes	2⊠ No	Specify:			Specia	y: wh:	ite		
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Maryland	be fi	Be	17. Father's Name (First, Middle,	Lest)							e (First, Middle,	Melden Sumel	ne)			
Ž	should Ind Meni	2	August Kibler						E1	sie	Jones					
ā	2 sh end fs m		19e. Informent's Name/Relations	hip (Type, Print)		19b. Meilir	ng Address	(Stree	t end Numb	er or Run	al Route Numbe	r, City or Town	, Stete, Zir	Code)		
	s 1 end 2 should if Heelth end Men item 27 is marke other traumatic		Nancy Smith	daughter					sboro	Rd	Greensb	oro,Mai	ylan	d 216;	39	
ore			20e. Method of Disposition	0 T B 0	0.000	e of Dispo etery, cren	sition (Nen	ne of ther ple	eca)		Date	20c. Location	- City or To	own, Stete		
Ĕ	Peges nent of } nt: If ite		1 Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (S		tate		emete		ŕ	Nov	.1,1999	Dentor	. Mar	vland		
altimore,	구두목글		21. Signature of Funeral Service	Licensee	50110	22	. Name en	d Addr	ess of Fecili	ty				Land		
m	Depariment Important in Sunce.		1/2,	14	* /						in Fune					
			220 Parts Enter the disease or		and the death of	1	O Box	_			sboro,M		1 21	639		
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on ear	ch line.	Do not ent	er the mod	e or ay	ing, such as	cardiac	or respiratory en	rest,	1	Approximete tntervel Betw Onset end D	ween	
	Physician /Medical		Immediate Occupy (Fig.)				$\Delta_{\Lambda}$	4		7	).		1	L 1	/eetii	
	Examiner		Immediate Ceuse (Final disease or condition resulting in death)	e Co	Due to (or es	(m)	LIV	U	ern	/	1150	ase		YEA	MS	
		L.	resulting in deality		Due to (or es	conseq	quence of):							/		
	po tis	Examiner		h									i			
	and trans	Cam	Sequentially list conditions,		Due to (or es	e conseq	uenca of):									
68760,	e exe		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury										1			
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Ö	the sy th	hys	$\wedge$ $\vee$		-	ig iii tiio di	- 6	uuse gi	ivon in r oit		10)	/		babiy 4⊟U		
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Records,	The law requires thet the death site has been signed by the etter page 2 should be deteched for u	D D	A		- 1 -	- 11	+		2		24a. Wes	en eutopsy	24b. W	ere eutopsy fir	indings	
<u>o</u>	v require been si should	Completed	ria		100	114	201	0	N			med?	CO	eileble prior to impletion of ca		
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<u></u>		ပ္ပ									1□ Y	es 28 No	1[	Yes 2	No	
Vital	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?							e of Deet	h (Check only of	he)				
ot	d is	2	1 Yes 2 No	Hospital: 1 ☐ Inp	patient 2□ER	/Outpetien	nt 3□ DO	A Ot	her: 4□ Nu	ursing Ho	me 5 Resid	ence 6 □Ot	her (Specil	fy)		
_	ding Pl h. After ti funera	ü	27. Manne of Death 1 ☐ Naturel 5 ☐ Pendin	28e. Dete of (Month.	Injury 28 Dey Year)	b. Time of Injury	2	8c. Inju Wo	iry et ork?		28d. Describe h	ow injury occu	rred			
0	Attending or death.	atic	2 Accident investig	9		,,	М		]Yes 2□	No						
Division	or Attendent efter deat Director:	iffe	3 ☐ Suicide 6 ☐ Could a determ	inod 200. Placa 0	f Injury - At home	, ferm, str	eet, factory	, office			28f. Location (S City or Tow		ber or Run	el Route Numt	ber,	
	s effer i Direct	Certification:	4 I Hollicide	building	g, etc. (Specify)						Ony or You	n, Siele)				
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	iai	29a. Certifier 1 Certifyin	g Physicien: To the b	est of my knowled	dge, deeth	occurred	et the ti	ime, date en	d place,	end due to the d	euse(s) end m	anner es s	tated.		
	P Ho P Fu	edlcai	(Check only 2 Medical one)	Examiner: On the bas end menne	is of examinetion or stated.	end/or Inv	vestigation,	in my	opinion, dee	th occurr	ed et the time, o	lete end placa,	end due to	the ceuse(s)	1	
	To th Withir To th	Ž	29b. Signature end title of certifie				290	Licen	se number		- 2	29d. Date signe	ed (Month,	Dey, Year)	-	
	->-0		\ A.	ne, V	.62	M	0	D	3) -	37		10	-79	OPP		
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				who completed cause												
			James Sides MD		ket Stre		Dent	on,	Maryl	and	21629					
	Sta		31. Dete filed (Month, Day, Year)	A	gistrer's Signeture	1										
	Registi	ar	ASON - 1 1		carred	14	Mar.									



	BALTIMORE, MARYLAND 21215-0020
	). BOX 68760
	P.C
	RECORDS,
	VITAL
_	OF
`	DIVISION

MANY H. Steverson

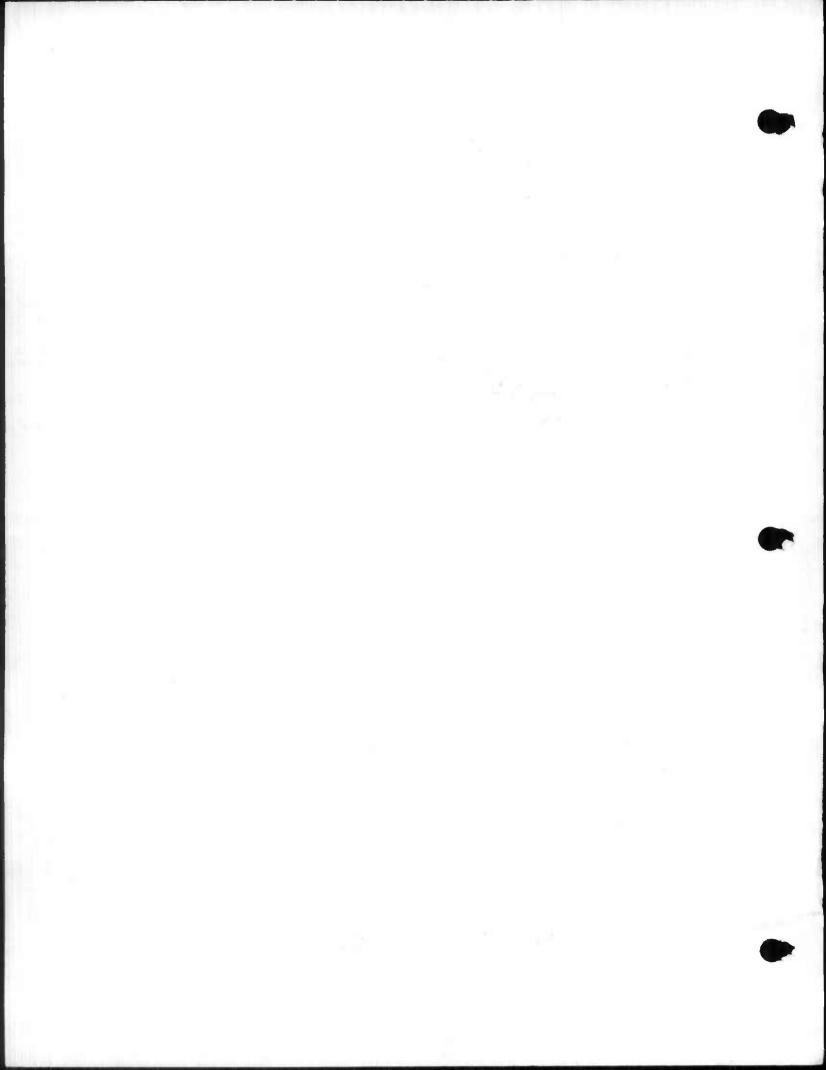
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhers hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

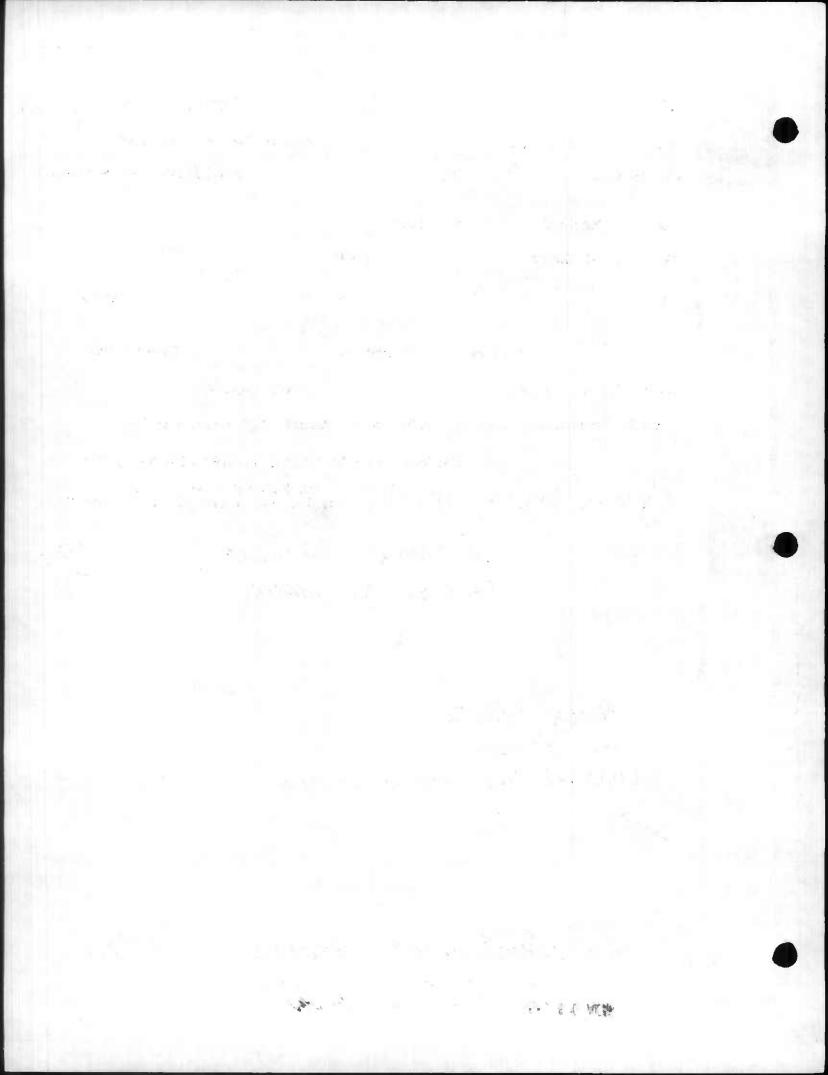
IMPORTANT: If item 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4 0

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEP. CERT	ARTMENT OF HEALTH AI										
	1. DECEOENT'S NAME (First, Middle, Last)	N SteVENSON	S		DAY YEAR	3. TIME OF DEATH							
		5. SEX 6. AGE (In yrs. lest birthds			6. BIRTHE	PLACE (State or Foreign							
	34 - 76 07 5 .	1   M 2   YRS	MONTHS DAYS HOURS N	JAN. 3/1	1912 MAL	yeard							
Œ	98. FACILITY NAME (If not institution, give street  MANOK: WANO		96. CITY, TOWN OR LOCATION	-	9c. COUNTY OF DE								
CTO	RESIDENCE OF DECEDENT		Tr. UC035	ANDE	Somerset-								
DIRECTOR		ELSE 6	PRI ANNE			10d. INSIDE CITY LIMITS?							
3AL	10a. STREET AND NUMBER	1 - 0 1	101. ZIP CODE			N OF WNAT COUNTRY?							
FUNERAL	11. MARITAL STATUS	JOSE SCHOOL Y	a 2/8	35T ISPANIC ORIGIN? (Specify Ye	UJ,	- American Indian,							
BY FI	1 Never Married 2 Married 3 Widowed 4 Divorced	Black, Specify	White, atc.										
ED B	15. DECEDENT'S EDUCA	ISINESS/INDUSTRY	AMBRICAN										
	(Specify only highest grade co	impleted) (Give kind	T'S USUAL OCCUPATION of work done during most of working T use retired.)		_ [0								
COMPLET	17. FATHER'S NAME (First, Middle, Last)	Nom		'S NAME (First, Middle, Maiden	Silf								
ш	SidNEY M.	Smith	Ant	ELINE IN	C(SON								
10 B	19a. INFORMANT'S NAME (Type/Print)	h 1	ING ADDRESS (Street and Number or		vn, State, Zip Code)	and							
	20a, METHOD OF DISPOSITION	DAUTHER 1/30	TEOADISPOSITION (Name of	7.00	DCATION - City or Tow	By Mac							
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	of from State cometes, cremetory of	or other place) Ry Chin	11/4/1 12	ANNR	md,							
	21. SIGNATURE OF PONERAL SERVICE LICEN	O /	22. NAME AND ADDRESS (	OF FACILITY 917	WEST 1	Abrilla 57							
	John A. C.	muce "	Sallisbap.										
	23. PART L Enter the diseases, or cor shock, or heart fellure. Lis IMMEDIATE CAUSE (Final	at only one cause on each line.	o not satisf this mode of dying	such as cardiac or resp	Piratory arrest,	Approximate interval Between Onset and Death							
	disease or condition resulting in death)	eare	2 mos										
_		10'0	5										
TIO	Sequentisity list conditions, if any, leading to immediats  DUE TO (OR AS A CONSEQUENCE OF):												
SI	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	resulting in death) LAST												
	PART II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause give	n in Part I. 24a. WAS AN	AUTOPSY 24b.	WERE AUTOPSY FINDINGS							
DICA	arteriosele	rotic Cardior	n. 17		2 ST NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
MEDI	Essential Hy	certennos.	Ruemia			1 ☐ YES 2 🙀 NO							
PHYSICIAN:	DID TOBACCO USE CONTRI  25. WAS CASE REFERRED TO MEDICAL		YES NO UNCER	TAIN 🗌									
YSIC	1 TES 2 NO 1	OSPITAL:    Inpetient 2   ER/Outpetient 3   DOA	OTHER: 4 Nursing Home 5 - Reside	ence 6 Other (Specify)									
	27. MANNER OF DEATH  1 Natural 5 Pending	28s. OATE OF INJURY (Month, Day, Year)	TIME OF 28c. INJURY AT WORK?  M 1 YES 2 N	28d. OEŞCRIBE HOW	INJURY OCCUREO								
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY — At home, terr building, etc. (Specify)		26f. LOCATION (Street	and Number or Rural Ro	oute Number,							
ETE	4 Homicide determined	, , , , , , , , , , , , , , , , , , , ,		City or Town, State;									
COMPLET		NN: To the best of my knowledge, death occion the basis of examination and/or investigation.											
E CO	296. SUBSTATURE AND TITLE OF CONTINE	The second of second of the se	29c, LICENSI		29d. DATE SIGNED (								
O BE	Sugara h.	Belless, h	L. D 20	4505	► 10 -3								
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH (ITEM 27) (7)	SET GROOM I										
	31. DATE FILEO (Month, Day, Year)	32. NEUIS MAN S SIGNATURE	302 CHINABET	RICY DR. SA	USBURY,	MD 21801							
	N/1V (1 1 1990	11 Deneura 19											



	1. Decedent's Nar	ne (First, Middle, Las	t)	6 4	Certifica			, T	2. Dete of De		Vaar	3. Time of Death		
siçian edical	CAthe	rine			TE		RMA		Octok	T	1999	4:05 AM		
miner		(If not institution, give		or)					cation of Death	4c. County				
eral	5. Social Security	Memorial Number 6. Se		Age (In yrs. last b		er 1 Year			8. Date of Bird (Month, Da			ice (State or Foreign y)		
	014-01-8	3592	□ M 2 <b>)</b> XF	84	Yrs. Months	Days	Hours	Min.	03/02/	1915	Massa	chusetts		
	Usual Residence	10b. County		10c. City, Tox	vn or Location	_			10d. Inside City Limits					
to	MD	Harford		Aberd	een							1 ☐ Yes 2 ☐ No		
Oirec	10e. Street end Ne					ip Code				10g. Citizen of \	Whet Count	y?		
Funeral Director		rrett Cou				001		1.0.10		USA - 14. Raca - American Indian,				
oy Fune		ried 2 Married 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Detes	s? No	13. Was Deci		an, Mexicar Specify:		cify Yes or No Rican, etc.)	Black Specify	ck, White, e	tc.		
ted t		15. Decedent's Edi	ucation		a. Decedent's Us	uei Occup	pation			16b. Kind of B				
Be Completed by	(Spe Elementary/Sec	cify only highest gree ondary (0-12)	de completed) College (1-40	or 5+)	(Give kind of w life. DO NOT	ork done use retired	during mos d)	t of workin	g					
;	17 Fotheric Na	(First Middle Land)	2 year		Secreta	ry	10 14-01	nela Alama-	(Eirat Middle		nmen	τ		
		(First, Middle, Last)	VOS							Maiden Suman	10)			
2		Joseph Ha lame/Relationship (7)		19	b. Mailing Addres	ss (Street			eough	er, City or Town,	Stete, Zip (	Code)		
	Patricia	Testerma	n- Daug		01 Garr		Court	, Ab	erdeen	, MD 2	1001			
	20a. Method of Dis	position Gremation 3 🔲	Removal from Stat	comoti	of Disposition (Ne ery, cremetory or	other plea	ce)	i	Date	20c. Location -	City or Tow	m, State		
	4 Donation	5 Other (Specify	)		rd Memo				/3/99	Aberde	en, M	D		
		uneral Service Licans	_	110	22. Name a				al Hom	e, P.A.				
	Mitchell-Smith Funeral Home, P.A.  123 S. Washington, Havre de Grace, MD 210  23a. P. htt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Bell onset and onset and													
н	shock or he	art failure. List only o	ne cause on each	line.								Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)  e. ASPIRATION PICCIMONIA ZDA  Due to (or es a consequenca of):  FALLOPIAN Cell CANCER.											2 D43.		
r	resulting in death)		+	Due to (or es a	consequence of	):	6.4					21/1		
- Li	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest  b. FALLORIAN Cell CANCER.  Due to (or as a consequence of):  C.  Due to (or as e consequence of):											246		
Exa														
dicai	C. Due to (or as e consequence of):  resulting in death) Lest  Due to (or as e consequence of):													
_			d											
Physician/M	Part II Other stan	iftcent condittons co	ntributing to dooth	but not requities	in the undertales	cause air	von in Dard		23h Did	tohacco use co	ntribute to	the cause of death?		
hys	. a.t.n. Other sign	Ploseral	L DP	- Cut not resulting	ar the briderlying	oansa Alv	งอก สา <b>" ส</b> เป			Yas 2 No	3 Prob			
by		, works	The	een							T			
Completed		B12 de	heien	,						en eutopsy rmed?	con	re eutopsy findings llable prior to apletion of cause		
шр	7-1	What I	1	)							of d	eeth?		
0	25. Was case refe	rred to medical	PHIHY	Secon	VDAgey 7	OCA	MCCA.	of Dooth	(Check only of		1 [	Yes 2 No		
0 8	examiner?	1	Hospital:	itient 2 ER/C	utpatient 3 🗆 D	OA Oth	nor:			dence 6 □Oth	ner (Specify	)		
on: T	27. Manna of Dea	th 5 Pending	28e. Date of In (Month, L		Time of tnjury	28c. Injur Wor	ry et rk?	2		now injury occur				
	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be			M arm atract facts		Yes 2		Of Location /	Street and Number	har or Dure!	Route Number		
Cati		determined	be de 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)							Street end Numi wn, Stete)	Jer of Hural	noute ryum <i>ber</i> ,		
ertificati	4 Homlcide													
dical Certification:		1 Certifying Phy 2 Medicat Exam	iner: On the basis	of examination a										
edical	4 Homicide  29a. Certifier (Check only	2 Medicat Exam		of examination a	nd/or investigatio	n, in my o			ed et the time,		and due to	the ceuse(s)		
Medical Certificati	4 Homlcide  29a. Certifier (Check only one)	2 Medicat Exam	iner: On the basis	of examination a	nd/or investigatio	n, in my o	opinion, dea		ed et the time,	date and place,	and due to	the ceuse(s)		
edical	4 Homlcide  29a. Certifier (Check only one)	2   Medicat Exami	iner: On the basis	of examination a stated.	nd/or investigation	n, in my o	pplnion, des	th occurre	ed et the time,	date and place,	and due to	the ceuse(s)		



State of Maryland / Department of Health and Mental Hygiene 36356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Grace Julia Toomey November 8,1999 10:10 A.M · /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Genesis Eldercare The pines Easton Talbot If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Deys 1 M 2 M F 88 Months Nov.6, 1911 Delaware Director 222-01-7574 Usuel Residence of Decedent the Marylend 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits ahow. permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryle Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28s-1 show any Injury or other traumatic event, the Medical Examines insulate nother Easton MD Talbot 1 No Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21601 610 Dutchman's Lane United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No if Yes, Give Yeer or Dates: 14. Race - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married Toomer Grace Toomer Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Sportswear Seamstress 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Ella Morris Reynolds Fred Reynolds 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 6 3 2 19a. Informant's Name/Relationship (Type, Print) Clemmie V. Beauchamp/niece 4529 Houston Branch Rd., Federalsburg, 20a. Method of Disposition
1 □ABurial 2 □ Cremetion 3 □ Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dele 11/12 Federalsburg, MD Bloomery Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Framptom-Hawkins-Eskow Funeral Home 216 N. Main St. Federalsburg, MD 2 Michael 7. Eskow 21632 Approximete Intervel Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical < 24 forts Brain stem thrombosi Examiner Due to (or es e consequence of): Examiner Cerabral anteri Uncertain physician end the buriel-tran Sequentially list conditions, if eny, leading to Immediete ceuse. Enter Underlying Ceuse (Diseese or Injury fhat initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) 80 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. signed by ti 1 Yes 2 No 3 Probably 4 Unknown Rheumatoid withritis þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed peeu has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: after death. Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neture! 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 170 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0 D10938 Nov. 8, 1999 Robert W. Trever, M. D. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Robert W. Trever, M.D. 7696 Ocean Gateway, Easton, MD 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State

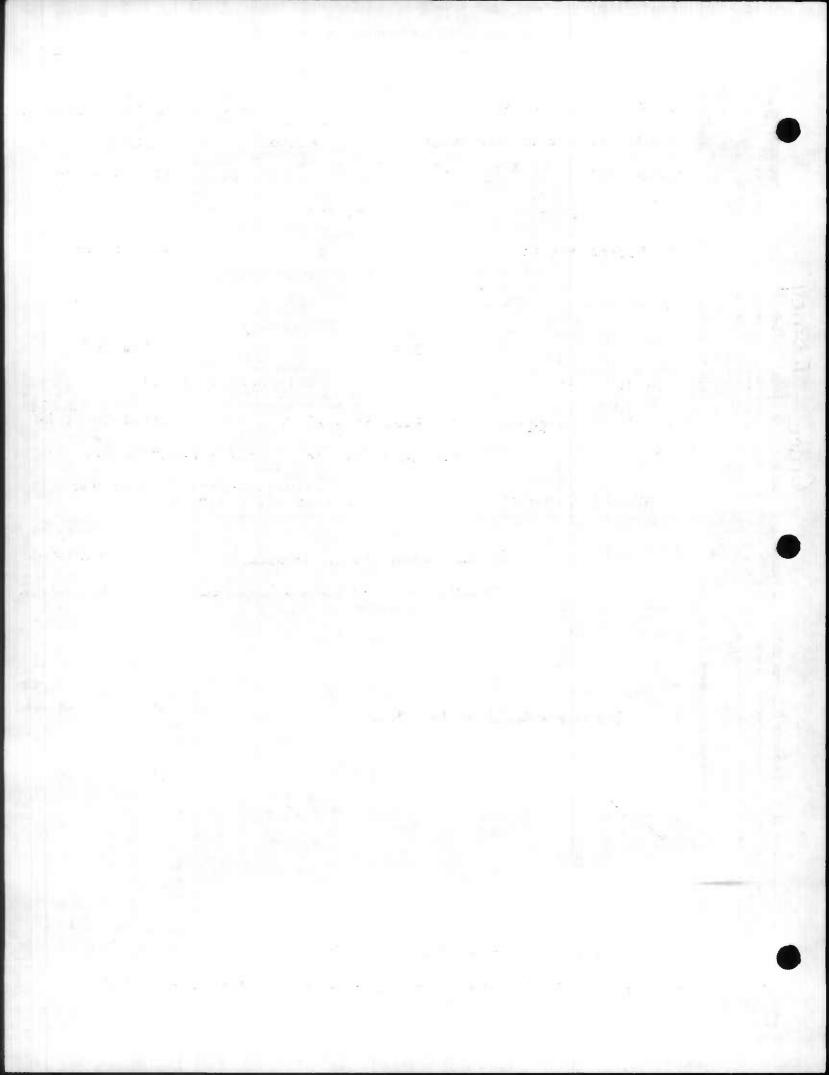
DHMH 16 Rev 6/95

Registrar

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Deneva



Mary Wooster Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Month Year Mary West Wooster 5:55 PM 11 1999 /Medical 4e. Facility Nama (If not institution, giva straet and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Pocomoke City Hartley Hall Nursing Home Worcester Hours Min. 8. Date of Birth (Month, Day, Year) 3/25/1907 If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) 6. Sax Birthplaca (State or Foreign Country) **Funeral** 10 M 26 F Yrs. Director 92 Maryland 213-05-2013 10a. State 10b County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2□ No Director Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 9 Central Ave. Funeral 21851 USA or items 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ♣No If Yes, Giva 11. Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Raca - American Indian, Bleck, Whita, etc. efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à Specify: 3 Midowed 4 Divorced white 'natural', Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If tem 27 is marked other that any figury or other traumatic event array. 10 Seamstress Clothing 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be John Thomas West Annie Conaway 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9 Central Ave., Pocomoke City, MD 21851 John Wooster (son) 20b. Placa of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 11/10/99 Pocomoke City, MD First Baptist Cemetery 21. Signature of Fugterel Service Licansee 22. Neme end Address of Fecility Holloway Melson Funeral Home, P.A. molla 9 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset and Death Physician /Medical Immadiata Ceusa (Final Right Hemorrhagie Infarct disease or condition resulting in death) Examiner Examiner The law requires that the deeth certificate be executed buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequance of): Box 68760. attending physician for use es the burie Physician/Medicai Dua to (or as e consequenca of): P.O. Pert II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? upertension 1 Yes 25 No 3 Probably 4 Unknown signed t Records, þ page 2 should 24b. Ware eutopsy findings available prior to Completed Oslyanthrite 24e. Wes en autopsy performed? complation of causa of deeth? certificate 1 Yas 2 No 1 ☐ Yas 2 ☑ No of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Naturel s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide in by t 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours at To the Funeral C completely filled 29a. Certifier 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and manner as steted.

| Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and mennar stated. Medicai (Check only one)

State Registrar

31. Date filed (Month, Day, Yaar) NOV 0 9

M.

29b. Signeture and title of certifier

GREGORIO

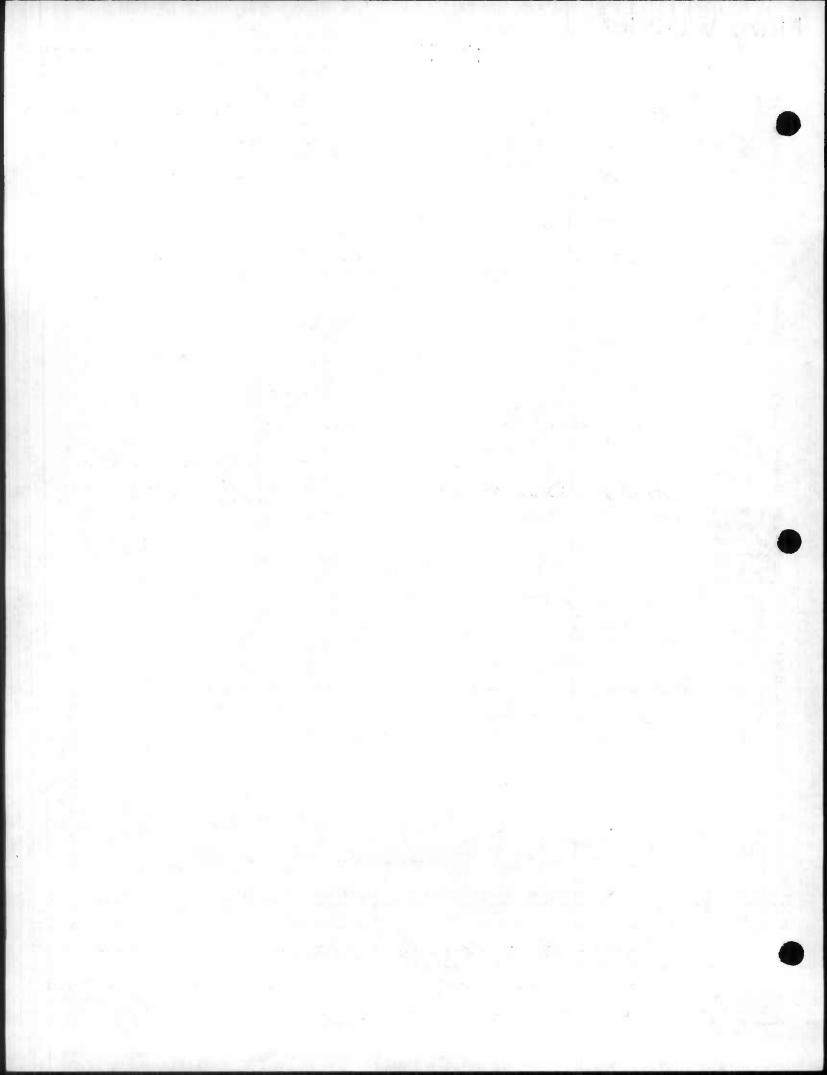
M. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

ulias

BELLOSO, MD; 5302 CHINABERRY DR.; SALISBURY, MD 21801

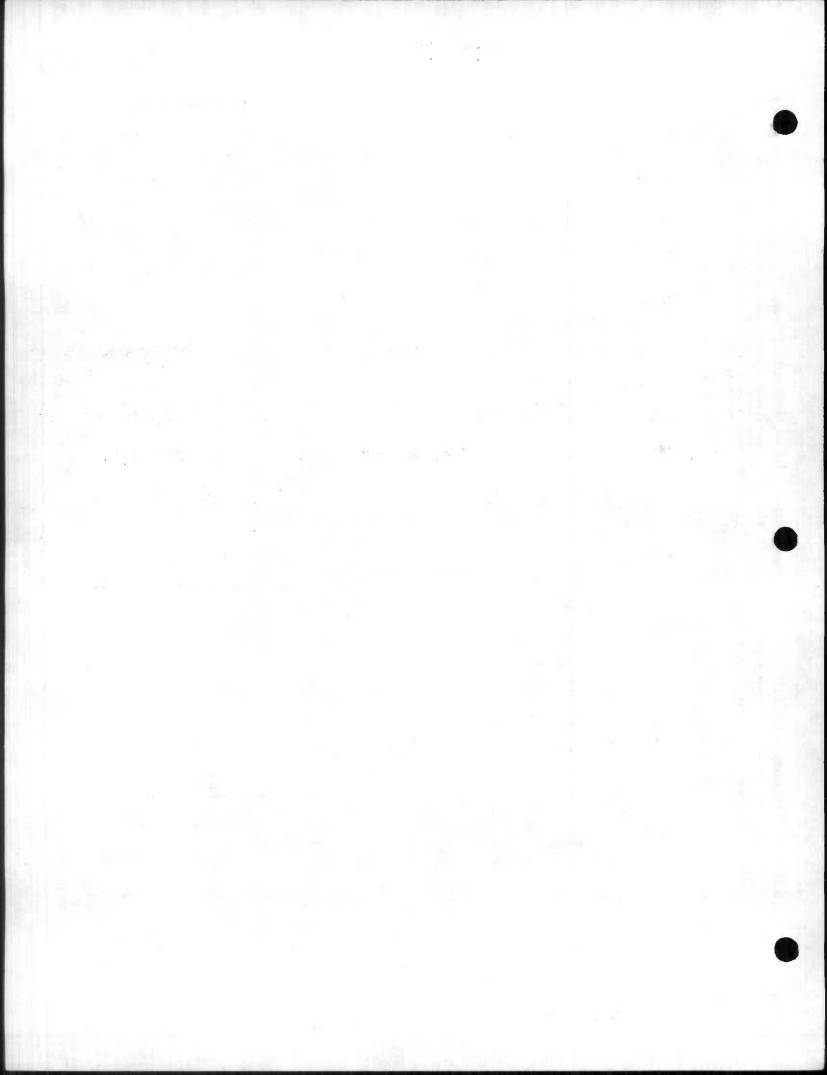
29c. License number

29d. Dete signed (Month, Day, Yeer)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

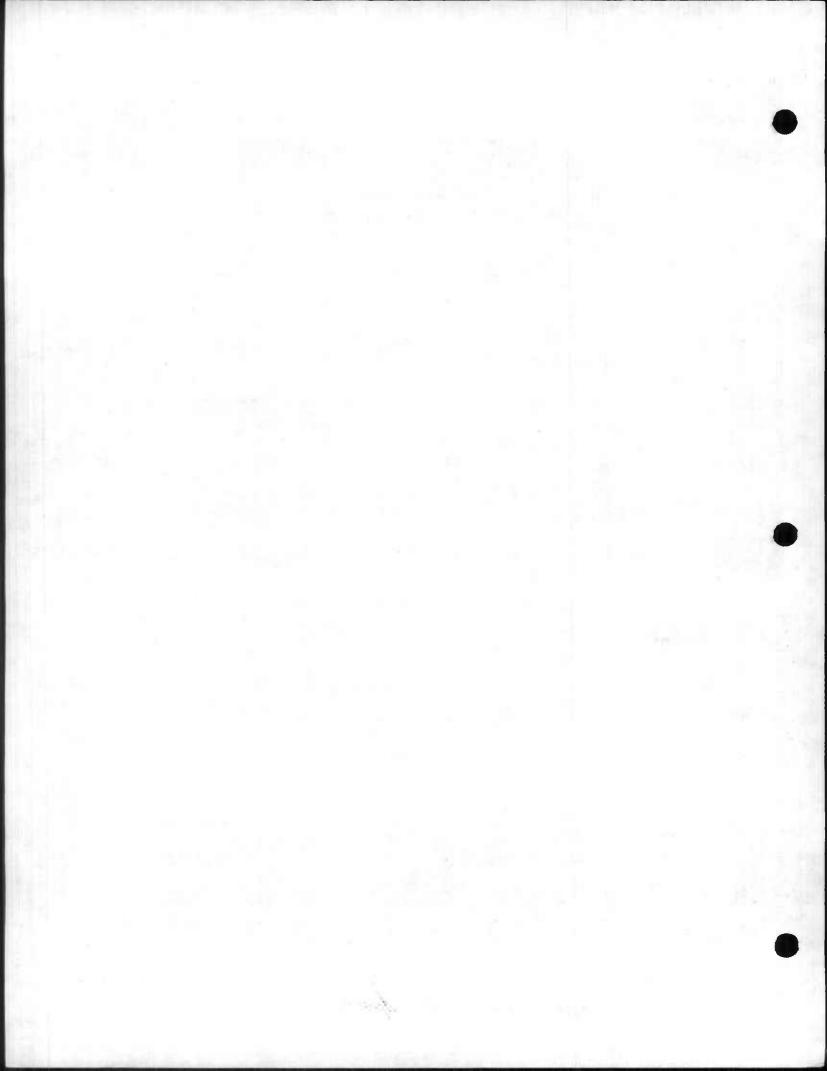
Physician	Decedent's Name (First, Middle, La.		Ce	ertificate of	Death	2. Date of Death Month		3635	Death			
/Medical	MILDRED MAE WI	LLIAMS				Novembe		29 1510				
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or Lo	cation of Death	4c. County of					
	PENINSULA REGION		CENTER		SALISBUR		WICO	MICO				
Funeral Director	5. Social Security Number 6. S 2.1.4-3.4-7.4.9.3 Usual Residence of Decedent	ex 7. Age (In	yrs. last birthday	Months Days		8. Date of Birth (Month, Day, 10/22/2	pate of Birth Month, Day, Year)  0 / 22 / 22  9. Birthplace (State or Foreign Country)  VIRGINIA					
deeth with the Maryland ms 23a or 28a-f show c.must be notified at nersi Director	10a. State 10b. County		c. City, Town or	Location				10d. Inside City				
octo	MD WORCEST	ER P	OCOMOKE	1								
or 2	10e. Street and Number			10f. Zip Code		10	g. Citizen of Who	at Country?				
123a	703 CEDAR STRE	ET		2185			USA					
5 22 5	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	rin U,S.   13	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Special, Mexican, Puerto	ecify Yes or No- Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc.  Specify: WHITE					
ted the bet	15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occu	pation	16	16b. Kind of Business/Industry					
A Z I Z I S-U led within 72 ho lygiene. Ner then "neturn it, the Medical Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retire	during most of working)	ng						
filed with Hygiene the ent, the	8		HOUS	SECLEANI	NG	I	OMEST	RIC				
be filed to the filed other went, the become the filed to	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Sumame)					
Vian Sould be Mental Me	CHARLES MEARS				MAE DAV	IS						
	19a. Informant's Name/Relationship (1 GARY T GILLESP		19b. Mai	iling Address (Stree	t and Number or Rura KE RIVER	RD, PC	City or Town, St.	ate, Zip Code) 218 E CITY, N	851 MD			
Pages 1 ent of He y or oth	GARY T GILLESPIE / (SON) 7570 POCOMOKE RIVER RD, POCOMOKE CI  20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  4 Donation 5 Other (Specify)  20c. Location - City or Tow											
Physician /Medical	23a. Part 1. Enter the disease, or compshock, or heart laiture. List only	an mo1124	y I	OCOMOKE	MELSON CITY, M ing, such as cardiac o	D 21851	1	Approximate Intervat Betwo	eath			
Examiner	disease or condition resulting in death)	a	1.00192.6	1								
<u> </u>	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN TWO IN COLUMN TO THE PERSON NAMED IN COLUM		to (or es e cons	0400000	Cana	in Brzo	bear les	actatio.				
death certificate be executed eath certificate be executed of for use as the buriel-transit sician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
Co dfor att	Part II. Other significant conditions or	patributing to dooth but no	iven in Best I	Part I. 23b. Did tobacco use contribute to the cause.								
ras that the death cert ilgned by the attending the deteched for use. by Physician/M	Peralysis 20							Probably 4 U				
line pino	Pour Nuthi.	and states	va ; . c	martia,	DV7.	24a. Was an perform		24b. Were autopsy lin available prior to completion of cal of death?				
of the state of th						1 ☐ Yes	2 D(No	1 Yes 2 N	No			
slen: stor. Be G	25. Was case referred to medical				26. Place of Deeth	(Check only one	)					
hysici hysici il direc	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpati	ent 3 DOA Ot	har	me 5 Residen		(Specify)				
tal or Attending Physicien: The lew name of the descriptions of the description of the de	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye	ar) 28b. Tirne Injury	of 28c. Inju	rry at ork? ] Yes 2 □ No	28d. Describe hov	w injury occurred					
tal or At lied in by Certiff	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, larm, s	treet, lactory, office		281. Location (Stre City or Town,		or Rural Route Numb	ier,			
n 24 houp n 24 hou ne Fune pletely fil		yeician: To the best of my iner: On the basis of exa and manner stated.										
To the Common Co	29b. Signature and title of certifier			29c. Licen	se number			Month, Day, Year)				
	* hildeld	Oa		250	512	1	1.5.90					
3	30. Name and address of person who of	completed cause of death	(Item 23a) (Type ふん らしいか	Print)	Sciepmy +	vo 31801						
State Registrar	31. Date liled (Month, Day, Year)	32. Registrar's	Signature	6 /								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended #4c, NLS, 11/9/99, Allegany County State of Maryland / Department of Health and Mental Hygiene Amended #31, NLS, 11/10/99, Allegany Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Marshall White 1999 0055 November /Medical 4c. County of Death Allegany 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner -Alleghany Cumberland Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth American 12, 1948 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 10M 20F 51 220-52-7606 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits or 28a-f show rai', or items 23s or 28s-f shore Examiner must be notified at 1 Yes 2 No Director WV Mineral Wiley Ford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Route 1 Box 16 26767 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after ants of Heelib and Mentel Hygiene. ants if item 27 is marked other than "natural; or ite any or other treumatic event, in the deal 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white à 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Camp Supervisor Juvenile Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Marshall White (Newman) Gladys 2 19a. informent's Name/Relationship (Type, Print)
Charlotte A. White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Route 1 Box 16; Wiley Ford WV 26767 20a. Method of Disposition 20b. Placa of Disposition (Name of 20c. Location - City or Town, State 1 Kuriel 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Parl1/06 Cumberland, MD 22Scarperil Faraneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List cally one cause on each line. iff. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final March 1996 disease or condition resulting in death) Advanced Esophageal Carcinoma **Examiner** Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sicien and burief-transit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of). 80 been signed by the esthonial Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate funerel director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ≥ Inpatient 2 □ ER/Outpetient 3 □ DOA After this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after deeth.

Funerel Director: Al investigation 2 Accident the 6 Could not be determined To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by the 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner steted. Medicai 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0023371 4, 1999 November 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 143 Qamar U. Zaman Johnson Heights Medical Bldg. 625 Kent Ave. Suite 102 Cumberland 31. Date filed (Month, Day, Year) 32. Registrer's Signeture NOV-0-9-1999 Registrar 05



MELODY AMEND#2:	JAI 3A 3	NE WILLIAMS 27-28F PER M.E.(					artment rtificate				Re	ene g. No. 9 9	38		
Physici /Medic	_		ane W	lilliams						1		5, 1999		3. Time of Death 8:15 Al	
Examin	er	4a Facility Nama (If not in 13600 W	illiam	s Road			I Kiladaa		CUME	www. or Location of Death  BERLAND  4c. County of Death  ALLEGANY  24 Hrs.   8 Date of Birth					
Funeral Director		5. Social Security Number 218-02-0521  Usual Residence of Deced	1	M 2DF		last birthday,	Months	Days	Hours	Min. Ap	Pate of Birth Month, Day, 11 29	,1982	9. Birthplac Country	ce (State or Foreig	
ith the Maryland or 28a-f show	Director	MD A	County 11egan			ty, Town or Li Cumber					10	g. Citizen of V	What Country	I. Inside City Limits 1 ☐ Yes ②\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
5-UOZU 72 hours after death with the Marylar restural; or Herre 23e or 28e-7 ehow ideal Examiner must be notified at	by Funeral Director	13600 Will  11. Marifal Status  1 Never Married 2  3 Widowed 4 D	☐ Married	d . SE  12. Was Decedent Ever in U,S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:			Was Decede If Yes, speci	ent of Hi fy Cuba	1502 ispanic Orig n, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- n, atc.)	USA  14. Race - American Indian Black, White, etc.  Specify: White			
in y fall of A LA 10-0000 should be filed within 72 hours after of Mental Hygiene.  marked other than "natural" or it made event, on Medical Examin	To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elemantary/Secondary (0-12)  Collega (1-4or 5+)  16a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir													
Maryland of 2 should be file the and Mental Hy of 1s marked other traumatic event										ean Wa	, Middle, Maiden Surnama) an Walther				
DESILIMOTE, Maryland Z1Z1 parmit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mente.	Alan Williams Father 13600 Williams Rd., SE, Cumberland										land,	MD 21 City or Town	.502 n, Stata		
parmit. F Departm Importan any Injur		21. Signatura of Funeral S	service story	Meri		E.	2. Name and	uner	ral Ho	ome Re	1824 R	eister stown,	stown MD 2	Rd. 21136	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. List only		SMOKE IN	NHALATIO	N	or dynn	y, suur us		princey area	24		Approximate Interval Between Onset and Death	
v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trensit	edical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last	s, ta	b		or as a conse				4-					
The law requires that the death certifice. The law requires that the death certifice are been signed by the attending phy aga 2 should be detached for use es the	Physician/Med	d										23b. Did tobacco use contribute to the ca			
law requires the has been signed a 2 should be d	Completed by										24a. Was an perform	autopsy ed?	avail	e autopsy findings able prior to pletion of cause ath?	
OI VIIGHT Physician: The this certificate I	Be	25. Was case rafarred to rexaminar?	medical	Hospital:				Othe	or-	of Death (Ch		)		Yes 2□ No	
r Attending ter deeth. Irector: Aftei n by the fune	Certification: To	2XX Accidant	Panding investigation Could not be determined	28a. Date of (Month,	Injury Day Year) 5,1999 Injury - At h		ДМ 28	Sc. Injun Work	4LI NU	28d. V I ( 28f. l	Describe how CTIM OF Location (Stre City or Town,	State) 360	IRE	Route Number, AMS RD.	
To the Hospital of within 24 hours of To the Funeral D completely filled in	edical	(Check only one)	edical Exam	ysician: To the beariner: On the basi	est of my kno		vestigation,	in my op	oinion, deat	d place, and d	fue to the car the time, da	use(s) and ma te and place,	anner as stat and due to t	led. he cause(s)	
To Too	2	29b. Signature and title of 30. Name and address of s	hus	U, K	of/Seath (Iter	71 23a) (Type			onumber C.M.E		29	d. Data signe	4.1	1999	
Sta		THEUNU 31. Date filed (Month, Day	NE A	Milkup 32. Fleg		1 Penr	Stre	et,		more,	Maryla	and 212	201		

MON 1 8 1898 / See & South

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** NOVEMBER 3, 1999 HATTIE VIRGINIA WALLACE 0903am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs, last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Dey, Year) | Months Deys | Hours | Min. | May 15, 1915 5. Social Security Number 9. Birthplece (Stete or Foreign Country) Maryland **Funeral** 1□M 2⊠F 216-50-5457 **Director** Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be notified at once. 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Calvert Port Republic 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1955 Scientists Cliffs Road 20676 USA Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Someone else's home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Willis Commodore, Sr. Nettie 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11470 H.G. Trueman Road Lusby, MD 20657 Darlene Hutchins/Daughter 20e. Method of Disposition
1 △Buriel 2 □ Cremetion 3 □ Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 11/8/99 Prince Frederick, MD 4 ☐ Donetion 5 ☐ Other (Specify) Greater Bible Way Chr. 22. Name end Address of Fecility Sewell Funeral Home 21. Signeture of Funeral Servica Licenses Placlys 9. Seve 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Cardio- Resp Examiner Due to (or es e consequence of): Examiner physician end s the buriel-trensit the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of) CAD Physician/Medical Due to (or es e consequenca of): 88 for use as signed by the a P.O. Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, þ Completed 24e. Wes en eutopsy 24b. Were eutopsy findings peen eveileble prior to completion of cause of deeth? performed? certificate hes 1 Yes 2 No 1 Yes 2 No funeral director. 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 22 ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 3 DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred After t Certification: 1- Neturel 5 Pending investigation death. or Attendary of Piece of Inc. Attendary of Inc. Add in by the fu 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Dicompletely filled in 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

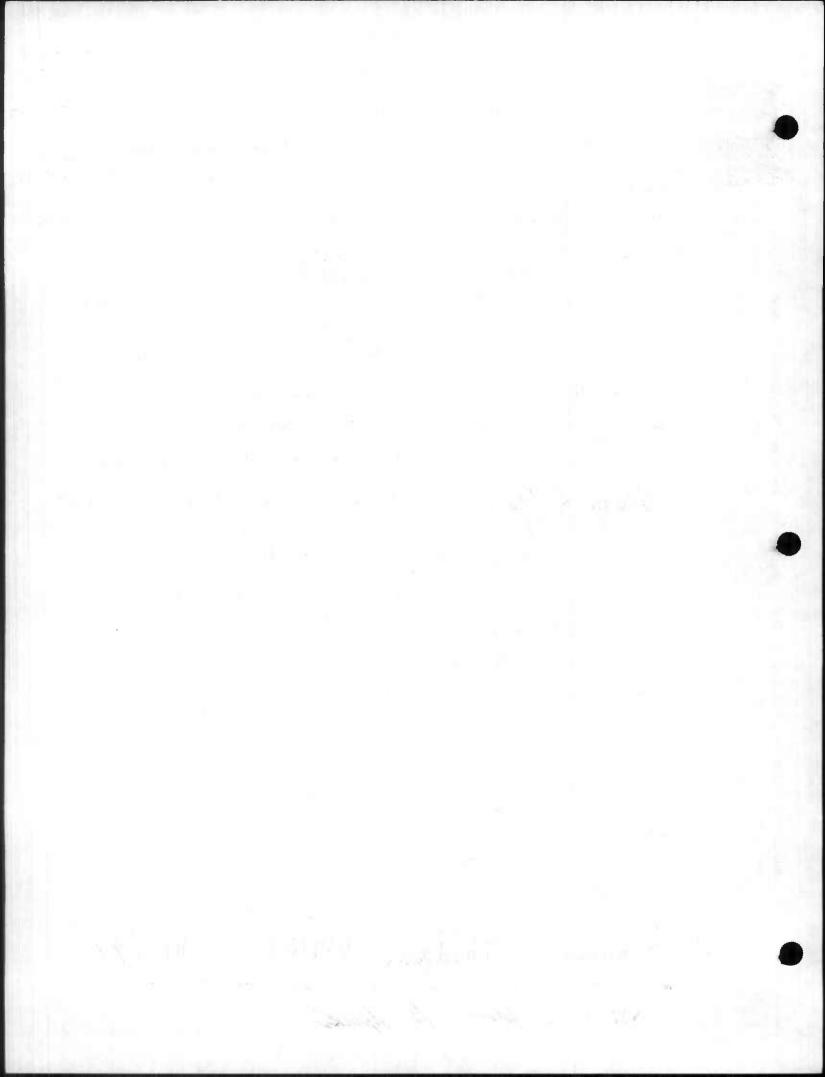
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end manner stated. 29a. Certifier edical (Check only 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 11-4-99 D50290 MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) M.D., PRINCE FREDERICK, MD DHIREN H. SHAH, 20678 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State NOV 0 5 1999 > Registrar

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					Maryland	l / Depa <i>Cei</i>	artment of l tificate of	Health and Death	d Mental Hy	/giene 9 (	3 3 6	362
	Physic /Medi Exami	cal	Decedent's Nama (First, Midd     WILLIAM     4a. Facility Nema (If not institution)	4b. City, Town,	2. Date of D Month Novem or Location of Dea	ber 3,	Yaar 1999	Time of Death				
	Funeral Director		Calvert Memo 5. Social Security Numbar 217 32 9847 Usual Residance of Dacadant		pital Aga (In yrs. la 90	st birthdey) Yrs.	If Undar 1 Yaar Months Deys	if Under 24 H		irth ay, Year)	9. Birthplaca ( Country)	(Stata or Foreign Maryland
	Marylend -f show lied at	tor	10a. Stete 10b. County Maryland Anne	cation Dea	le			nside City Limits				
21215-0020	h with the 23e or 28e	Funeral Director	10e. Street and Number 10f. Zip Coda 20751							10g. Citizen of W		
	be filed within 72 hours efter death with the Marylend that Hygiene.  9d other than "natural", or items 23s or 28s-f show event, the Medical Exeminer must be notified at	by	3 ☑ Widowad 4 □ Divorced ff Yas, Give Yaar or Datas:				Vas Decedant of Pas, specify Cub		(Specify Yas or N arto Rican, atc.)		a - Amarican Inc k, Whita, etc.	dian,
	I within 72 ho iene. r than "natur: r wedical	Completed		nt's Education est grada completed) College (1-4	or 5+)	16a. Deced (Giva life. L Water	ant's Usual Occu kind of work dona DO NOT usa ratire	pation during most of w	vorking	16b. Kind of Bu		
Maryland 2	d fa b	To Be C	17. Fathar's Name (First, Middle, Thomas Frankli	n Welch				Ida M	Nama (First, Middle, Meidan Sumama)  Mae Deale			
é,	1 end Health am 27		19a. Informant's Name/Reletions Mrs. Ida Mae W  20a. Mathod of Disposition 1 □ Burial 2 ▼Cramation 4 □ Donation 5 □ Othar (S	illiams / r	cer cer	P.O.	Box 190 sition (Nema of patory or other pla tan Crer	Deale		751 20c. Location	City or Town, St	itata
Baltimore,	permit. Peges Depertment of Important: If it any injury or o		21. Signatura of Funarai Service		ass of Facility	ome, P.A		dria, V				
	Physician /Medical Examiner		23a. Part 1. Entar tha diseasa, o shock, or haart failure. List Immediata Causa (Final diseasa or condition resulting in death)  Sequentielly list conditions, if any, leading to Immediata	a. End	Due to (or exercise)	Do not ente	Heal uence of):		iac or respiratory of	s A	Interv	roximete vel Between et and Death
ox 68760,	eath certificete be executed ettending physician end I for use es the buriel-transit	v/Medical Examiner	if eny, laading to immediata cause. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last	a Asa	Due to (or e	es a consequ	gence of):	40				
, P.O. Box	the d	/ Physician/M	Part II. Other algnificent condition	ona contributing to deat	h but not rasult	ing in the un	darlying causa gi	van in Part 1.		tobeceo uae con Yes 2 No		cause of deeth?
Records,	e law requires that hes been signed t je 2 should be det	Completed by								s an eutopsy ormed?	evailable	ion of ceuse
Vital B	Page ate	Ве Соп	25. Was case referred to medica					26. Placa of D	1 □ Death (Check only	Yas 2 No	1 ☐ Yes	2 No
n of	g Physic ter this conerel dire	၉	1 Yes 2 No  27. Manner Deeth 1 Natural 5 Pandir 2 Accident investi	gation		R/Outpatient 8b. Tima of Injury	28c. Inju Wo			idance 6 Othe		
Division	To the Hospital or Attendin Within 24 hours after deeth. To the Funeral Director: At completely filled in by the fu	Certification:	3 Suicida 6 Could datarm  29a. Certifier 1 Certifyir	nined 288. Placa of building,	etc. (Spacify)		at, factory, office		City or To	(Street and Number wn, Stata)		ta Number,
	the Hos hin 24 ho the Fun npletely	Medical	(Check only 2 Medical one)	g Phyaician: To the be Exeminer: On the basis and mannar	s of examinatio	n end/or inv	astigation, in my	opinion, daath oc	ce, end due to the curred at the time,	, dete and placa, a	and due to the c	
	With CO CO	4	29b. Signature and title of certifie	eru (	asd	am	29c. Licans	3 Number	2/	29d. Data signed	Month, Dey, Y	(ear)
ક્ર			30. Nama and eddrass of person Dr. Kioumar	who complated cause o ce Yazdan				Freder	ick, MI	20678	, ,	
	Sta Registr		31. Data filad (Month, Day, Yaar)		istrar's Signatu	ra 4	1	,				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 36363 Certificate of Death 2. Date of Deeth

Physician
/Medical
Examiner
LAUTHITE

William Hill

**Funeral** Director

> show 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Medical Examiner must be notified at

Director

Funeral

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Completed

with the Maryland death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important if flem 27 is marked other than 1 any injury or other traumont.

**Physician** /Medical **Examiner** 

Physician/Medical

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Completed

Be

2

Certification:

Medical

Division of Vital Records, P.O. Box 68760,

	To the Hospital or Attanding Physician: The law requires that the death certificata be asscuted
12	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be datached for use as the burial-transit

Amend 10acef 1 /3/99

1. Decedent's Name (First, Middle, Last) Month Vee Kellah Morris Wiltsey October 31,1999 11:30pm 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Manor Easton Talbot Months Deys Hours Min Fe b. 23, 1922 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foreign 10 M 20 F Georgia 252-38-6484 77 Yrs. Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits DE Talbot Seaford Maryland -St-Michaels 1X Yes 2 No 10e. Street end Number RR2 Box 392F 10f. Zip Code 10g. Citizen of Whet Country? 19973 P.O. Box 21663 America 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 🔯 No It Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3. Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementery/Secondary (0-12) 11Yrs. College (1-4or 5+) Education Librarian 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Tharpe Earl Odel Kellah Morris Tharpe 19e. Interment's Name/Retationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O. Box 159 St Michaels, Maryland 21663 Peggy W. Morey 20b. Place of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State Eastern cremetos nother elece) 1 ☐ Burial 2X Cremation 3 ☐ Removel from State 11/1/99 Lewes, Delaware 4 Donation 5 Other (Specify) Crematorium 21. Signature of Meners 22. Name end Address of FecilityWatson-Yates Funeral Home Front & King Sts. Seaford, Delaware 19973 is that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, see on each line. Approximete Intervel Between Onset end Deeth or complication only one ca hrmic Congestive Failing Immediete Ceuse IFM disease or condition resulting in death) Due to (or es e consequence ot): Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence ot): Due to (or es a consequenca of): Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably # Unknown william with Cerebilla dunither 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveitable prior to completion of cause ot deeth? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exemlner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No 27. Manner of Deeth 28c. Injury et Work? 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier 🕊 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifi 29c. License number 29d. Dete signed (Month, Dey, Yeer) 30. Neme end eddress of person who completed cause of deeth (llam and (Type, Print)

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Registrar

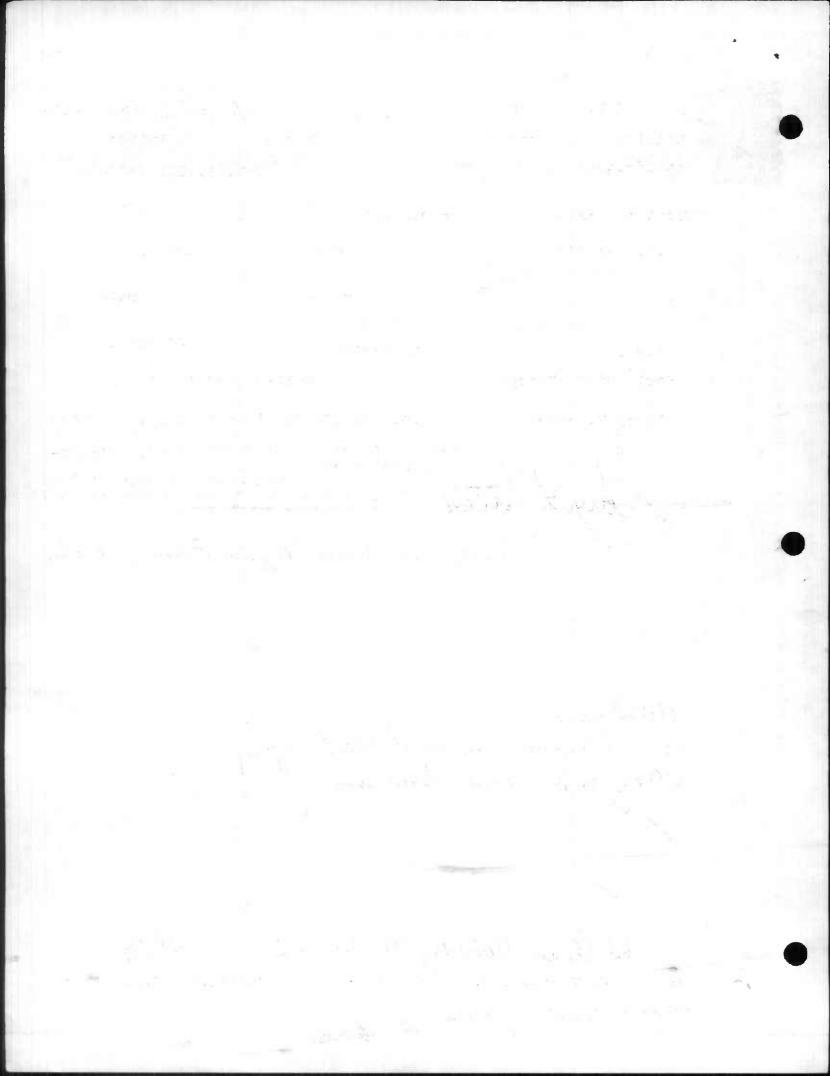
31. Date filed (Month, Dey, Year)
November 10 120 591039

William H. Wood, Jr.

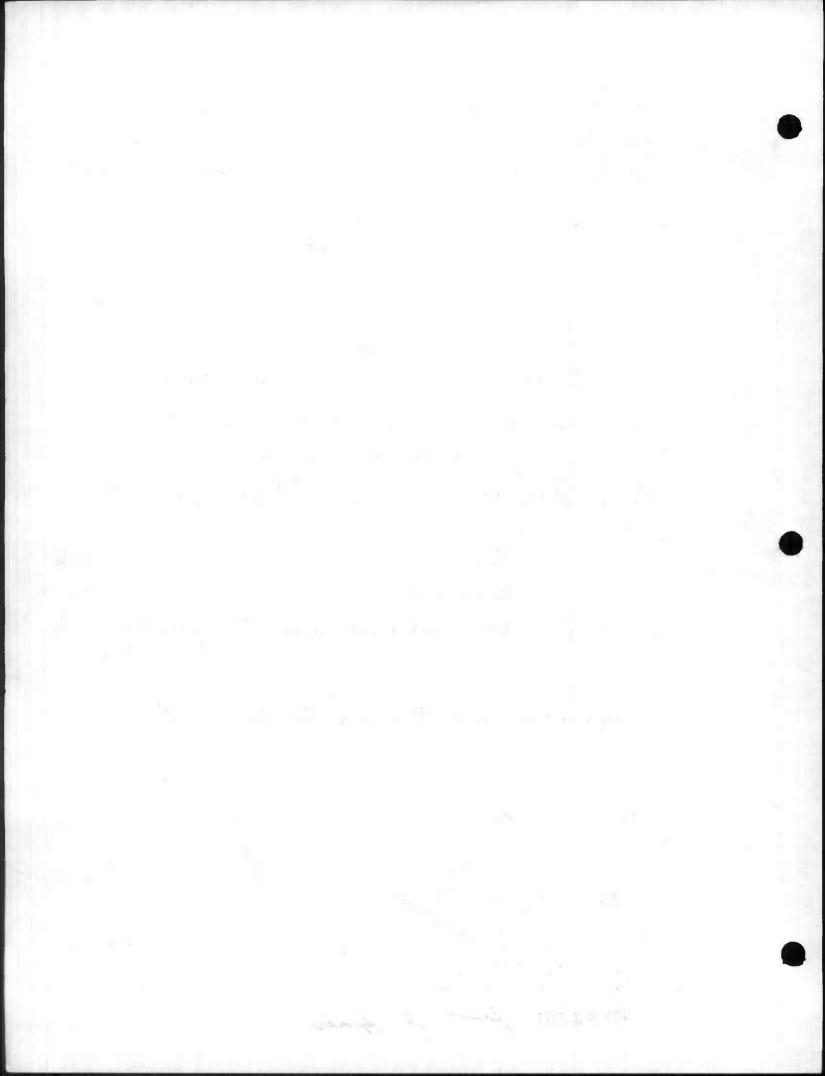
32. Registrer's Signeture

G. Sparks

M.D. 506 Idlewild Ave. Easton, Maryland 21601



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	Physic		Decedent's Name (First, Middle, Las     Margaret Ha	•	pp			Nonth Vorembe	1/ 10	3. Time of Deeth 99 2158					
	/Medi Examii		4a. Fecility Name (If not institution, give Carroll County G				4b. City, Town, or Loca Westminst	ation of Death	4c. County of	Deeth					
	Funeral Director		5. Social Security Number 6. St 216–22–1885		ge (In yrs. lest birth 74 Y	day) If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, 12-1-19	24 1	Birthplace (State or Foreign Country) Maryland					
	nyland show		Usual Residence of Decedent  10a. State 10b. County		10c, City, Town					10d. fnside City Limits					
	the Ma 28a-f	Director	MD Carrol  10e. Street end Number	.1	Syk	esville 10f. Zip Code		10	g. Citizen of Wha	1 ☐ Yes 24 No					
	th with 23a or	ai Di	2720 Liberty Road	l		217	84		at Country i						
21215-0020	s i end 2 should be filed within 72 hours efter deeth with the Maryland I Heelth and Mentel Hyglene. Item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funerai	11. Meritei Status  1 Never Merried 2 Married  Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Yeer or Dates:		13. Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2 🛣 No	dispenic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American Indien, White, etc. White					
15-0	natur	eted	15. Decadent's Ed (Specify only highest gra	ucation de completed)	16a. 0	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	pation during most of working	7	6b. Kind of Busin	ness/Industry					
212	d withir giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or :	5+)	Homemake			Domes	tic					
Maryland	uld be file Jentel Hy rked othe tic evant,	To Be C	17. Fether's Neme (First, Middle, Last) Walter Edward H	lobbs			18. Mother's Name ( Harrie	First, Middle, Me ett Arri	aiden Sumeme) ngton						
Man	12 sho h and h r ie ma		19a. Informant's Name/Relationship (7	Route Number,	City or Town, St	ete, Zip Code)									
Baltimore,	permit. Peges 1 and 2 Department of Heelth s important: If Nem 27 is any injury or other tra once.		Mr. Gregory Zepp  20a. Method of Disposition  1 X Burial 2 Cremation 3		20b. Placa of I cemetery	6313 Yeoho Disposition (Neme of cremetory or other plea									
Eim	ortmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signeture of Funeral Service Licen												
Ba	Depermination of the second of		HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400												
	Physician		23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only of	olications that caused one ceute on each li	the deeth. Do no	t enter the mode of dyir	ng, such es cardiac or	respiratory arres	st,	Approximete Interval Between Onset and Death					
	/Medical Examiner		Immediate Ceuse (Final disease or condition	Sex	newe					luk					
	LAGIIIIICI	ē	resulting in deeth)		Due to (or as e co					0 . 4.					
	and trensit	Examiner													
68760,	cete be executed physicien end the buriel-trensit														
	death certificete be executed e ettending physiclen end of for use es the buriel-trensis	/Medical	resulting In deeth) Last  Due to (or as e consequence of):  d.												
Box	death certifi e ettending p od for use es	Physician/M	Part fl. Other signifficant conditions contributing to deeth but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute												
P. 0	that the de led by the deteched		Metral Value	400	☐ Probably 4 ☐ Unknown										
Records,	law requires the es been signed 2 should be de	eted by	THE TOTAL CONTRACT	regarda	, ,	and early	_ 1 vs	24a. Was an		24b. Were autopsy findings eveilable prior to completion of cause					
	0 - 0	Completed						1 ☐ Yes	a ⊠No	of death? 1 ☐ Yes 2 ☐ No					
Vital		Be C	25. Wes case referred to medical examiner?				26. Place of Death			10 165 20 140					
of <	Physician: this certific ral director,	ို	1 ☐ Yes TXNo	Hospital: Inpatie			4 La Nursing Home								
	After fune	tion:	27. Manner of Deeth  1. Natural 5 □ Pending 2 □ Accident investigation	28e. Date of Inju (Month, De	y Year) 28b. Tir Inj	ury Wor	yat 28 nk? Yes 2 □ No	d. Describe hov	v injury occurred						
Division	I or Attendi efter deeth. Diractor: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Inj	ury - At home, fam c. (Specify)	n, street, factory, office	28	of. Location (Stre City or Town,	or Rural Route Number,						
	To the Hospital or Attent within 24 hours efter deelt To the Funaral Diractor: completely filled in by the	edicai C	29a. Certifier (Check only one)  Certifying Phy Cer	rsician: To the best iner: On the basis of and manner sta	examination and	de in occurred at the tir of investigation, in my o	pinion, death occurred	at the time, dat	e end placa, end	d due to the cause(s)					
	To the within 2 To the comple	Me	29b. Signeture end title of cartifier			29c. Licens	e number	29	d. Dete signed (	Month, Day, Year) Ver 19664 21157 exercition, MO,					
1			30. Neme end address of person who c	completed cause of d	leath (lem 23a) (T	ype, Print)	o ravada		~00, S	21157					
				0-0-1-	work	~ 295 Stu	ner Ave	Sutit	307, we	esemble, MO,					
	Sta Registr		NOV 0 3 199		ar's Signatur	6. 1.	/ /								
DII	WI 40 Day 60	-		7		- popul	2								



	PER D.V.R. G777 11-22- #27-28F PER M.E.O. G777	11-22-99 J.A.	/ Department of I Certificate of		Reg. No.	99 3	6365					
Physician /Medical	1. Decedant's Name (First, Middle, I		2. Data of Death Month Day		3. Time of Death							
Examiner	4e Fecility Nema (If not institution, g		Death 4c. County of Death									
Funeral Director	5. Social Sacurity Number 6.	Sax 7. Aga (In yrs. las			8. Date of Birth (Month, Day, Year) September 21 1 1		place (Stata or Foreign ntry)					
and and	Usual Rasidanca of Decedant  10a. Stete 10b. County	10c. City,	Town or Location			-	Od. Inside City Limits					
ith with the Merylan 23s or 28s-f show unit be notified at	MA		BALLIM	ORE			1 des 2 No					
vith the Mer or 28a-f si be notified Director	10e. Street and Number	1		10g. Citiz	zen of What Cour	ntry?						
23a (2)		LE Rd	212	1.15		USA						
natural, or items 23a or 28a-f show older Examiner must be notified at steel by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Evar in U,S. Armed Forcas?  1 ☐ Yes 2 No If Yas, Giva Yaer or Detes:	dispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Americ Black, Whita, Specify: /3 L	atc.						
ygiene. er than "natural" it, the Madical Ex Completed b	15. Decedent's (Specify only highest of Elementery/Secondery (0-12)		16a. Decedent's Usuel Occul (Giva kind of work done life. DO NOT use retire	pation during most of work d)	ing	ld1184	1					
		a (First, Middle, Maiden										
Mental H wrked off artic ever	ARTHUR IE	E ALBRITA	FON	SXIVIA	HENDA	-17501	1					
h and M	19a. informant's Name/Ralationship	Town, State, Zip	Code)									
	SXLVIA MCKI	Md 2	1215									
if item 2	5XLV/A MCKN/6ht 9900 / 1/25DH/E Kd, 19450 MA 213  20a. Method of Disposition  1 Burial 2 MCramation 3 Ramoval from Stata  20b. Place of Disposition (Name of cematary, crematory or other place)  Date  20c. Location - City or Town,											
ury.	4 Donetion 5 Other (Spec	HEIMO	RE,									
Departmen Important any injury odge.	21. Signature of Fune al Service Licensee  22. Nama and Addrass of Facility 4600 41144 4611  23a. Part 1. Enter tha disaesa, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, ozbeart failura. List only one cause on each lina.  25. Nama and Addrass of Facility 4600 41144 4611 4611 4611 4611 4611 461											
	23a. Part1. Enter tha disaesa, or co shock, or beart failura. List on	mplications that caused the deeth. y one cause on each lina.	Do not enter tha mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximata tntervel Between					
hysician /Medical xaminer	Immediata Causa (Final disaasa or condition resulting in daath)	a. Coccuine & Dua to (or a	heroin Over	dosa			Onset and Death					
thysician and the burial-transit dical Examiner	Sequentially list conditions, if any, laading to immediate cause. Entar Undarlying Ceuse (Disease or injury											
£ # P	that initiated events resulting in death) Lest  Due to (or as a consequence of):											
e attending phys od for use as the siciar/Medic	Part II. Other significant conditions	23b. Did tobacco	co use contribute to the cause of death?									
d by the leteche				bably 4 Unknow								
as been s 2 should				24a. Wes an autop performed?	av	ere autopsy findings allable prior to impletion of cause death?						
page Com	Bearing the second				1 □ Yas 2 0	1 No 1	□Yas 2 No					
ertific sctor	25. Was casa rafarred to medical axaminar?	Hospital			h (Check only one)							
£ 5	1 ☐ Yes 2 No		Voulpatient 3D DOX		oma 5 Residence 6		(y)					
After	1 Accident invastigati	(Month, Day Year)	Injury Wo	rk?	28d. Describe how injury UNKNOWN	y occurred						
rs after deeth.  si Director: After ti led in by the funera  Certification:	2 Accidant Invastigati 3 Suicida 6 Could not determine	he	1143 24110	28f. Location (Street and	d Number or Run	al Routa Number,						
Direction of the control of the cont	4 Homicide	building, etc. (Specify) STREET (F(	a, farm, street, factory, office		700 BLK. FREMO		ALTO. MD.					
Within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fune.  Medical Certification	29a. Certifier 1 Certifying F	hysician: To the best of my knowled miner: On the besis of axamination and mannar stated.		ma, date and place,	end due to the cause(s)	and menner as s	tated.					
Within comp	29b. Signatura end titla of certifier		29c. Licens	se number	29d. Date	a signed (Month,	Day, Year)					
	Darlen Felt	th MD	1248	38	Octo	ber 30, 1	1999					
	30. Nama and addrass of person who	completed causa of death (Item 2	3a) (Type, Print)		1 - 0							
	Darlene Fidl	er, mb al	South Greens 2 1999	Street,	Baltimore	MD	21201					
State	31. Data filed (Month, Day, Year)	32. Registrar's Signatur	2 1000	mercar 1	& spark							
Registrar	October 30, 1999	- NUV Z	2 1999	. /	//							



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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Q Q Amended Item #7 perFH G777 11/22/99 EW 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Day WEM BER 4a Facility Nama (If not institution, giva street and number) b. City, Town, or Location of Death 4c. County of Death N/A 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplace (Stata or Foreign 10M 20 F Months Hours PENNSYLVANIA Davs 218-05-5952 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. tnslda City Limits 1 Yes 2□No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4000 N. CHARLES STREET APT.#1214 21218 J.S.A. 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-tf Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: WHITE 3 M Widowed 4 Divorced Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY 12 YEARS CLAIMS SPECIALIST 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) HARRY **BOSK CECELIA** HYATT 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 6 CARRIAGE WALK COURT BALTO., MD 21234 MR. HARRY BOSK -NEPHEW 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) B'NAI ISRAEL CONGREGATION-11/14/1999 BALTO., MD 21. Signature of Funeral Service Licensea 22. Nama and Addrass of Facility SOL LEVINSON BROS., INC.soli 8900 REISTERSTOWN ROAD BALTO., MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final disaase or condition resulting In death) Dua to (or as a consequance of). Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) won Due to (or as a consequence 23b. Did tobacco use contribute to the cause of death? 24 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 R/Outpatient 3 DOA 28d. Dascribe how Injury occurred 28a. Dala of Injury (Month, Day Year) 28b. Tima of Injury er of Death 28c. Injury at Work? Hatural 5 Pending invastigation 1 Yas 2 No

The lew requires that the death certificate be axecuted use as the burial-transit Box 68760. P.O. of Vital Records, Physician: After this Division or Attending within 24 hours after death. To the Funeral Director: A

Physician/Medical Examiner

þ

Be Completed

Medical Certification: To

(Check only one)

29b. Signature a

30. Name and add

31. Date filed (Month, Day, Year)

240

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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ò 238

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event, the Medical

Hygiene.

. Pages 1 and 2 should be file Iment of Health and Mental H-tant: If item 27 la marked oth jury or other traumatic even

permit. Page Department of Important: If any Injury or once.

**Physician** 

/Medical Examiner

Director

Funerai

þ

Completed

Be

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa refarred to medical minar? 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 \( \text{Homicida} \) 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Hedical Examiner: Of the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

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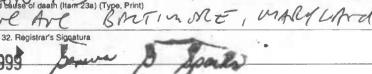
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filled In by

completely

To the Hospital

State Registrar



29c. Licensa number

29d. Data signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

Pause of death (Itam 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 3 6 3 6 7 State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** AULTHOUSE ROBERT RICHARD 2.30 AM NOVEMBER 17 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CENTER BALTIMORE N/A 8. Date of Birth (Month, Day, Year)
Oct. 2, 1934 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1XM 2□ F Days 204 26 9561 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend nant of Health and Mentai Hygiene. 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits Hygiene. Hygiene. other than "natural", or items 23s or 28s-f show rant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Linthicum Heights Maryland Anne Arundel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 295 Regency Circle 21090 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: P White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Electrical Engineer Westinghouse 12th 4 years 7 is marked other traumatic evant, i 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Sarah Brown George Robert Aulthouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health of Hea Linthicum Heights, Md. 21090 Phyllis Aulthouse / wife 295 Regency Circle 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State = 0 permit. Page Department of Important: if any injury or 11/20/99 Baltimore, Maryland Cedar Hill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ranurousa nations that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, one cause on each line. Approximete Interval Between Onset and Death **Physician** cancer with metastasis 17 days /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Examiner law requires that the death certificate be executed physicien and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attending pl signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy performed? Completed is certificate has director, pege 2 1 Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after deetl Director: 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09-10 120 NOYEMBER 17 1999 30. Name and eddress of person who completed cause of death (ttem 23a) (Type, Print) BALTIMORE KASIBHOTLA 3001-S. HANOVER ST SUMABALA 31. Date filed (Month, Day, Year) 32. Registrer's Signature

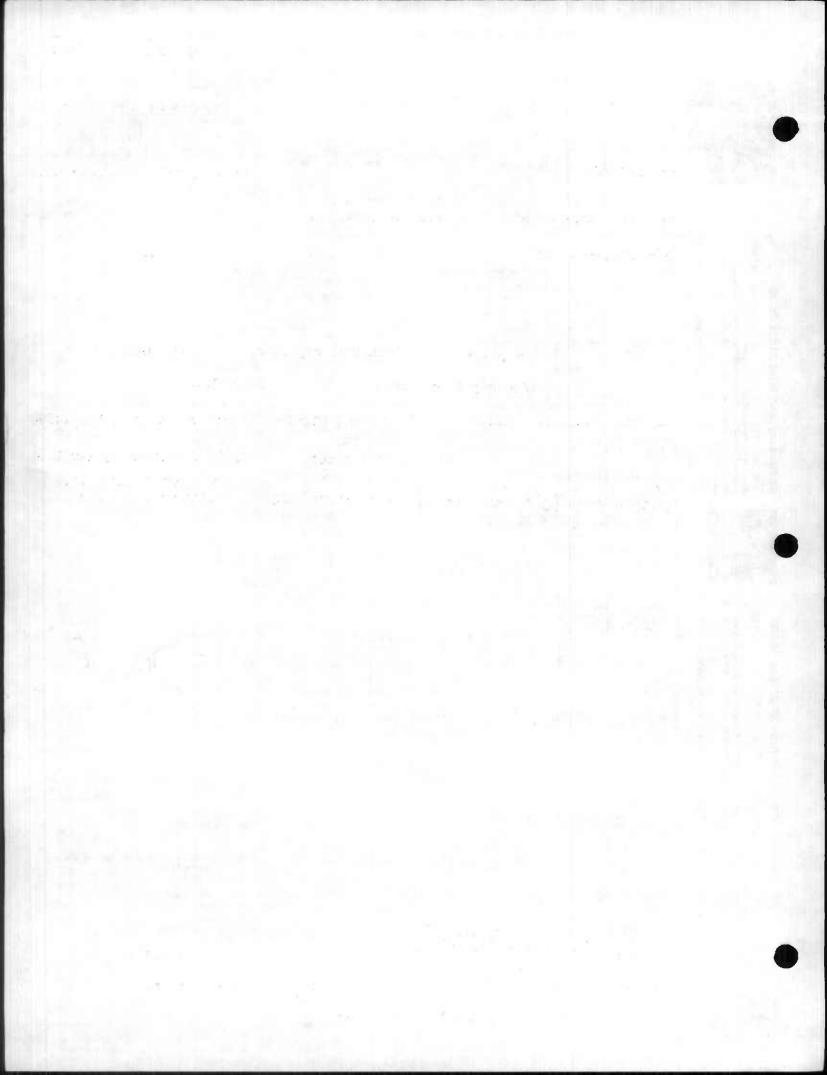
**DHMH 16 Rev 6/95** 

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 36368

				Certificat	e of	Death		R	eg. No.			
	1. Decedent's Nama (First, Middla,	Last)						2. Data of Deat	h	Man	3. Tima of Death	
Physician /Medical	Norman		November 1	Day er 16.1	Year	11:00 PM						
Examiner							wn, or Lo	ocation of Death	4c. Count			
É	7841 Lockwood				cimore	3						
Funeral Director	212-32-2274	. Sax 7. A 12XM 2□ F	ga (In yrs. last bir 64	Yrs. If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Data of Birth (Month, Day, Jan. 18	Year) 1935	Court	olaca (State or Foreign http: yland	
b s	Usual Rasidenca of Decedant  10a. Slata  10b. County		10c. City, Town	n or Location						1	0d. Inside City Limits	
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ar. or	11. Marital Status  1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forcas	12. Was Decedent Evar in U,S. Armed Forcas?  1 ∑Yas 2 □ No If Yas, Giva Yaar or Datas: 1954-56  13. Was Decedent of Hispanic Origin to Yas, specify Cuban, Maxican, P  1□ Yas 2 ☒No Specify:			ecify Yas or No- Rican, atc.)		ce - Americ ck, Whita, by:				
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Menta Menta Mic en To B	Arthur Pierce I	Brown, Sr.				Ag	nes	Hersh				
nd 2 sho lith and 1 27 is me r traume											Code) 1222	
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permit. Page Department of Important: If any Injury or attos.	1 Burial 2 Cramation 3 Chambral from Stata											
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/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in daalh)	a	SCU D Dua to (or as a c		or	opor	9	arleng	dia		3415	
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ettending ph for use as th	rasulting in oeath) Last	d	d									
death	Part II. Other significant condittons	contributing to death	but not resulting in	tha underlying o	ausa giv	ven in Part I	l.	23b. Did to	bacco use co	ontribute to	the cause of death	
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The lew te has age 2 age 2								1 🗆 Ya	s 20 No	10	∃Yas 2□ No	
	25. Wes case referred to medical	T				26. Place	of Deet	h (Check only on				
Physician: The lew requires the this cardificate has been signed rail director, page 2 should be consisted by the completed by the completed by the completed by the consistency of the	axaminar? 1 ☐ Yas 2 🗷 Vo	Hospilal: 1 ☐ Inpat	iant 2 ER/Ou	tpatient 3 D	OA Oth	war-		1		har (Specif	(ע	
Attending Physic deeth.  ector: After this by the funeral di	27. Menner of Death  1. Retural 5 Pending 2 Accident invastigat	28a. Dala of Injury (Month, Dey Year) 28b. Time of tnjury 28c. Injury at Work?						oma 56 Besidenca 6 □ Othar (Specify) 28d. Dascribe how injury occurred				
tal or Attending P is after death.  al Director: After the funers and in by the funers.	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicide datamine	d Zee. Piece of it	njury - At homa, fa tc. (Specify)	m, street, factor	y, office			28f. Location (St City or Town	reet end Num n, Stata)	ber or Rura	l Routa Number,	
To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Sertifying 1 (Check only one) 2 Medical Ex	Physician: To the best amtner: On the basis and manners	of examinetion end	, death occurred Vor investigation	at the tir	me, date en pinion, daa	d plece, th occur	end due to the cared at the tima, da	ause(s) end m ate and place,	enner es si , and dua to	tated. o tha cause(s)	
Neithin Somple	29b. Signatura and titla of certifiar	1	_	29	c. Licans	e number		2	9d. Data signe	ed (Month,	Day, Year)	
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12	30. Nama and addrass of person wh	o complated causa of	daath (Itam 23a) (	Type, Print)				el 21	- 1			
State Registrar	31. Data filed (Month, Day, Year)	32. Regist	rar's Signatura	8 %	ail	2			1			

**ORIGINAL** 

DHMH 16 Rev 6/95

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AME	IND ITEM:	#19		G778 12-3-9			(	Certifica	ate of	Death	1	Reg. No.	0	
	Physici	an		e (First, Middle, Last							2. Dete of De Month	Day	Yeer	3. Time of Death
	· /Medi	al	Monic	a Barl If not institution, give		erl				4b. City, Town, or	November Location of Death		1999	11:05 A.M
A	Examir	ier		sville Cor		01)				Catonsv			timo	re
	Funeral Director		5. Sociel Security N 140-01-6	197 6. Se		Age (In yrs.	lest birth	Month	der 1 Years Days	If Under 24 Hrs		h v. Year)	_	lace (Stete or Foreign itry)
	and		Usuel Residence of 10a. Stete	Decedent 10b. County		10c. Ci	ity, Town	or Location					1	0d. Inside City Limits
	with the Maryland a or 28a-f show Les northed at	jo	Maryland	Howard			Elli	cott (	lity					1 ☐ Yes 2 ☒ No
	r 28a	Director	10e. Street end Nur	mber				1	Zip Code			10g. Citizen of V	Whet Cour	atry?
	th wit	Funeral D	4941 We	bbed Foot	Wav				210	43		United	1 Sta	tes
21215-0020	ftar death w r items 23a		11. Maritel Stetus		12. Was Decedent Ever in U.S. 13.				edent of	Hispanic Origin? (Span, Mexican, Puer	specify Yes or No to Rican, etc.)		e - Americ	
	a 9	by	1 ☐ Never Marri 3 🗹 Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 20No If Yes, Give Year or Detes:							Specify	Whi	
	within ena.	Completed	(Speci	15. Decedent's Edu cify only highest gred endary (0-12)		or 5+)	- 9	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)  Homemaker  Own H						dustry
	other other	Bec	17. Father's Name	(First, Middle, Last)						18. Mother's Na	me (First, Middle,	Meiden Sumen	ne)	
lar	should be ind Mental marked o	10 8	John C	ravit						Virgi	nia Bra	zona		
Maryland	alth and 27 is m		19a. Interment's Na FRANK	ame/Reletionship (T)	pe, Print) On					tand Number of R Foot Way	urel Route Numb	er, City or Town,		
ore,	of Haal of Haal filem 2 r other		20e. Method of Disp	position ☑Cremetion 3 ☐F	Damaral from Ch		Place of D	Disposition (I	verne of or other pl	ece)	Nov. 22	20c. Location	City or To	own, State
Ē				5 Other (Specify)			etro	Crema	tory		1999	Catonsv	ille	Maryland
Baltimore	permit. Peg Depertment important: I eny injury o		21. Signatum al Fu	neral Service Licens	ee L					ess of Facility Vitzke's Columbia				Inc. MD. 21043
V <sub>j</sub>	, Physician		23a. Part1. Enter to shock, or hea	he diseese, or comp rt feilure. List only o	licetions that cau ne ceuse on eac	sed the dea h line.	th. Do no	t enter the m	ode of dy	ing, such es cardia	c or respiratory a	rrest,		Approximate Intervel Between Onset and Death
d	/Medical Examiner		Immediate Ceuse		a.	1	50,05	is						Lewday
п	LXummore	_	resulting in deeth)			Due to (	or es e co	nsequence o						0
Т	ted nsit	miner			. Urinary Travel						fletton	•		Jou days
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	e law has t	Completed	_ garve	Derrenala							of	mpletion of cause deeth?		
Vital		Bec	25. Wes case refer examiner?	red to medical						26. Plece of De	ath (Check only	one)		
of V	0 0	2	1 ☐ Yes 2 ☑	No	1 Inpatient 2 EH/Outpatient 3 IDOA					ther: 45 Nursing I	ner (Specil	51)		
	ng life	ation:	27. Menner of Deet 1 Neturel 2 Accident	5 Pending Investigation	28e. Dete of (Month,	Injury De <i>y Year)</i>	28b. Tir Inj		28c. Inj W	ury et ork? ] Yes 2 No	28d. Describe	how injury occur	rred	
Division	ai or Atta s aftar de ii Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of building	Injury - At h , etc. (Speci	nome, fam ify)	n, street, fac	ory, office		28f. Location ( City or To		ber or Run	al Route Number,
	the Hospital or Atlandi thin 24 hours aftar death the Funeral Director: A mpletely filled in by the fi	edicai	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami		s of examin								
	# E # E	Σ	29h Sinnature and	title of switter					non Linns	se number		29d. Date signe	d (Month	Day Voorl

To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by

29b. Signature and title of cuttle

MD

29c. License number 3 2 7 5 4 |

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year)

Nov 20, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

OEETMA RHIA J4367 HOLLING

FERRY RD, BALTIMENE, MD-21227

State Registrar 32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 36370 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dayt 1999. AM Month **Physician** JUDREEN BATTERSBY
4a Facility Name (If not institution, give street and number) NOVEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Center Randallstown | If Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 24, 1950 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F 49 Director 213-58-4031 Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantel Hygiana. Important: if Itam 27 is marked other than "natural", or hems 23a or 28a-f show with highly or other treumatic event, the Madical Examination and be notified at once. 10d. Inside City Limits 10a State 10h Counh 10c City Town or Location 1 ☐ Yes 2 No Director Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3810 Elmcroft Road 21133 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Supervisor Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Darwin H. McCracken Anna Pearl Presley 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Battersby - Son 350 1/2 Fair Avenue; Westminster, Maryland 21157 Baltlmore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore/Washington Crem. 11/22/99 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 POH FC 23a. Part1. Errier the disease, or complications that eaused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, nock or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIS 5 DAYS Examiner Due to (or as e consequence of) Examiner KETO ACID USIS DIABETIC physicien end the burief-transit the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): x 68760 FAILURE ENAL Physician/Medical Due to (or as a consequence of): signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that Records, þ 24a. Wes en eutopsy performed? Completed Were eutopsy tindings eveilable prior to completion of cause of death? 200 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Atte Division Attending 1 Natural 5 Pending investigation ofter death.
Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 Homicide 6 Houpital To the Hospital Within 24 hours To the Funeral completely filled edical Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie milla m.o 00 41410 Movember

AH

DHMH 16 Rev 6/95

State

Registrar

MORTHWEST

31. Date filed (Month, Day, Year)

NOV 2 2 1999

MUSTITAL

BANDAUS TOWN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUGINDER PMEHTA

REMTER

32. Registrar's Signatur

1993 Same 2001 1 5 VON

LERMON

BARNETT

State of Maryland /

Department of Health and Mental	Hygiene	00
Certificate of Death		33

36371

Physician	
/Medical	
Examiner	

**Funeral** Director

or 28a-f ahov Herne 23a

To Be Completed by Funeral Director

Department of Health and Mental Hygiene. Inputs siteld Important: If Itam 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Electrical Page.

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be exe Division of Vital Records, P.O. Box 68760,

**Physician** /Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by tha funaral director, pege 2 should be detached for use as the burial-transit within 24 hours after death. To the Funeral Director: After this certificate has

29a. Cartified

31. Date filed (Md

			Cer	unicate of	Deall	1	Reg	. No.	2	0011	
Decedent's Nama (First, Min						74	Date of Death Month	Day	Year	3. Tima of Death	
Lermon Eugene							NOVEMBER			11:07P.M	
4a Facility Nama (If not institu	tion, giva street and nu	mber)			4b. City, To	own, or Lo	cation of Death	4c, Coun	ty of Death		
SINAI HOSPITAI					BALT	IMORE	3	N/A			
5. Social Sacurity Number	6. Sax	7. Aga (In yrs. las	t birthday)	If Under 1 Yea		r 24 Hrs.	8. Data of Birth		9. Birth	placa (Stata or Foraig	
215 06 0045	1□M 2□ F	2	2 Yrs.	Months Days	Hours	Min.	(Month, Day, Y Dec 17,	ear) 1976	Cou	ntry)	
215-96-0045 Usual Rasidance of Decedant							Dec 17,	19/6	Mary	Tand	
10a. Stata 10b. Cour	ntv	10c. City. 7	Town or Loc	cation					Т.	10d. Inside City Limits	
										1⊠Yas 2□No	
MD N/A			Balt:	imore						123 103 20110	
10e. Street and Number				10f. Zip Code			100	. Citizen of	What Cou	ntry?	
4101 Rollins	Arranua			21207			TI	nited	Stat	es	
		edent Ever in U.S.	13 V	Vas Decedeni of	Hispanic O	rigin? /Sn				can Indian,	
11. Marital Status	Armed Fo	orces?	lf.	Yas, specify Cu	ban, Mexica	n, Puerto	Rican, atc.)		ack, Whita,		
1 Nevar Marriad 2 N	If Yas Gi		1	Yes 2000	Specify			Spec	ifv:		
3 ☐ Widowed 4 ☐ Divord	ed Yaar or D	atas:							ack		
15. Deced	ent's Education	1	6a. Deced	ient's Usual Occi	upation	nt of const	16	b. Kind of I	Businass/In	dustry	
(Specify only hig Elementary/Secondary (0-12	hast grada completed)	1 Aor Eu	lifa. D	kind of work don OO NOT use retir	ed)	SI OF WORK	(	Const	ructio	on	
12	college (	1-40( 3+)	Labor	rer							
17. Fathar's Nama (First, Midd	la i ast)		1000		18 Moth	er's Nams	(First, Middle, Ma	iden Suma	me)		
									,,,,,		
Lermon Eugen	e Barnett,	Sr.			Rob	in Ma	arie Will	iams			
19a. Informant's Name/Ralatio	nship (Type, Print)		19b. Mailin	g Address (Street	et and Numb	per or Run	al Routa Number, C	City or Town	n, State, Zij	p Code)	
Lermon Barr	nett SrFa	ther	3307	Edmonds	on Av	enue	Baltimo	re. M	D 212	229	
20a. Mathod of Disposition		20b. Plac	e of Dispos	sition (Nama of					- City or T		
1 Deurial 2 Cramatic	n 3 Removal from	Stata cem	atery, crem	natory or other pi	ace)		Nov 27				
4 Donation 5 Other	(Specify)	Mt.	Zior	Cemete	ry		1999 E	Baltin	nore,	, MD	
21. Signatura of Funaral Sarvi	cerLicensee	74.		. Name and Add							
V alour	711	IK /					Funeral H				
		000					re Street		TC1MO:	re, MD	
23a. Part1. Entar tha diseasa, shock, or haart failura. L	or complications that dist only one cause on e	caused tha daath. i	Do not enta	ar the mode of dy	ring, such as	s cardiac o	or raspiratory arres	t,		Approximate Interval Between	
		Λ		1 1	2					Onset and Death	
Immediata Causa (Final		111/11/11	20	(Rus L	5	100.	de		1		
disaasa or condition resulting in daath)	a	10011	116	ا کمیر	- 1 0		الاعمال		1		
		Dua to (or a	s a consequ	uence of):					į		
	b								î		
Sequentially list conditions,		Dua to (or as	s a consequ	uence of):							
if any, leading to immadiata cause. Enter Underlying									1		
that initiated evants	C	Dua to (or as	9 000000	ience of							
rasulting in death) Last		Dua to for as	a consequ	sono orj.					t		
	d										
Part II. Other significant cond	itions contributing to de	eath but not rasultin	ng in tha un	nderlying causa g	iven in Part	1.	23b. Did tobe	acco use c	ontribute 1	to the cause of death	
							1 ☐ Yes	200 No	3 □ Pro	bably 4 Unknow	
								1	00110		
									24h 14	lara autonov findir	
							24a. Was an performe		an	Vara autopsy findings vailable prior to	
									C	ompletion of cause f death?	
							A-1.	• • • • • • • • • • • • • • • • • • • •		1	
							11 Yes	2 No	1	Yas 2 No	
25. Was casa refarred to medi axaminar?						e of Deat	(Check only one)				
1XXYes 2□ No	Hospital:	Inpatient 20 ER	l/Outpatien	3 DOA	ther: 4 N	ursing Ho	ma 5 Rasiden	ce 6 🗆 O	thar (Speci	ify)	
27. Mannar of Death	28a. Data	of Injury 28	b. Time of	28c. Inj			28d. Describe how				
1 Natural 5 Pen	ding (Man stigation	th, Day Year)	Injury		ork? ]Yes 2∭2	(No	Scota:	O.A	d	1	
2 Accidant Inva	Id not be	177 0	1019		1		000)	Julied Hell			
Homicida deta	rmined 200 Flace	of Injury - At home ng, atc. (Specify)	e, farm, stre	set, factory, office	Ð		28f. Location (Stre City or Toya),	et and Nun Stata) 🌈	nder or Rui	rai Houta Number,	
			Sal	417			800 BI	KIN	Carre	le Are	
							-	1 7	- T V		

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State Registrar 111

of death (Item 23a) (Type, Print)

32. Registrade Signatura

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

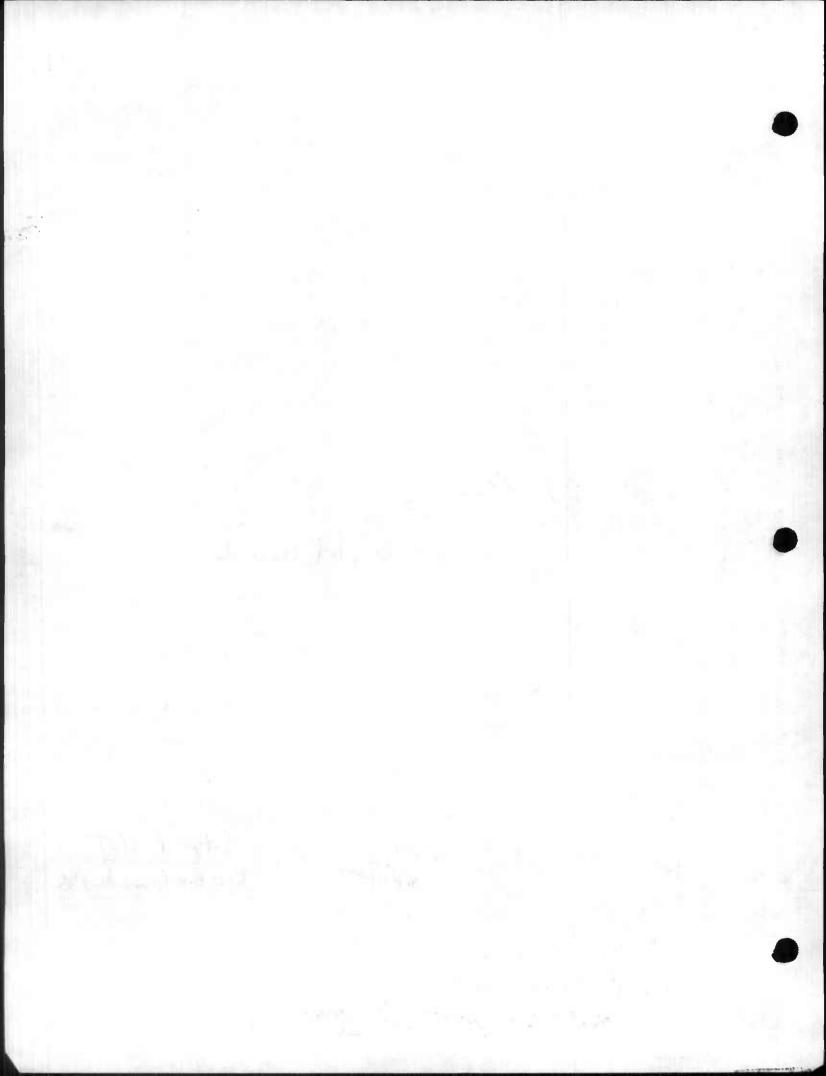
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) NOVEMBER 19,1999

Penn Street, Baltimore, Maryland 21201



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth **Physician** ALICE NOVEMBER 19, 1999 9:25 AM LOUISE BENTZ /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE ARUNDEL MARINER HEALTH OF GLEN BURNIE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 7. Age (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1 M ZOXF Months Deys Yrs. Director 83 7/25/1916 Virginia ∠29-24-9116
Usual Residence of Decedent with the Meryland pernit. Peges 1 and 2 should be filed within 72 hours after death with the Merylen Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any lujury or other traumatic event, the Medical Examinar must be notified at energy. 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes and No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 S. A.

14. Race - American Indien, 601 Mayo Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tecnician Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) 8 Mazzie Leftwich Robert Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 601 Mayo Road Glen Burnie, MD 21061 Irvin James Bentz 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 11/22 Glen Haven Memorial Park 1999 Glen Burnie, MD 22. Name and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service Licenses 1 SECOND AVENUE, S..W. GLEN BURNIE, MD. 21061 Rous 23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast shock, or heart tailure. List only one eause on each line. Interval Batween Onset end Deeth **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examine Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of cause of death? ahouid Completed 24e. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medicat axaminer? 8 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Pending investigation Division or Attending 1 (DNatural a after deeth.

I Director: Aft

ed in by the ful 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in Hospital 24 hours | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

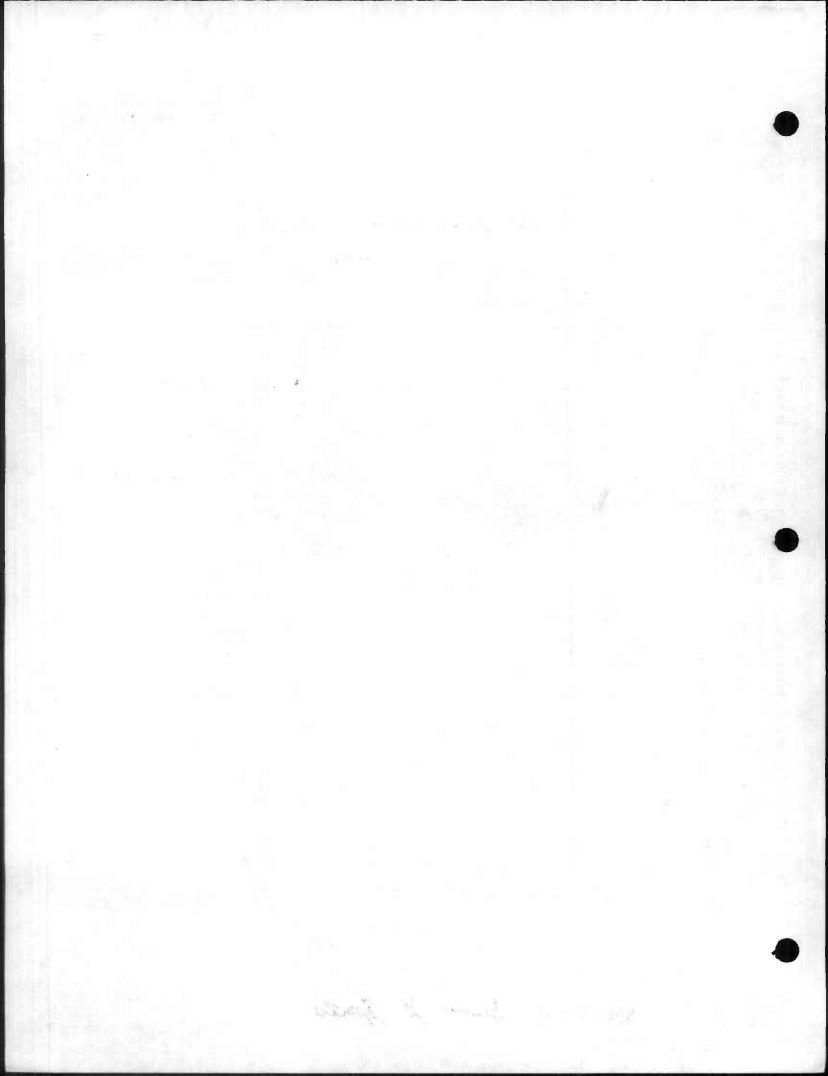
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fl (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D14136

State Registrar

31. Data filed (Month, Day, Year) NOV 2 2 32. Rigistrar's Signatura

Suite 201 Crain Towers Glen Burnie DONES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALJIT S. SAWHNE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day PHOEBE R. BERMAN 20,1999 Nov. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lutherville Baltimore 1116 Greenspring Valley Road If Under 1 Year 6. Sex 1 □ M 2√ F Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Yrs. 89 213-01-3096 Sept.30.1910 Callensburg, PA Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Lutherville Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1116 Greenspring Valley Road 21093 USA 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🟋 No Specify: White 3 D (Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Horse Farm Owner 4 Yrs College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Rhea Martha Schweitzer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) 1100 Harmony Circle West Chester, Pa. 19380 POA Peter B. Shreffley 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Service 11/22/99 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136 Timos) one 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Um6 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was en eutopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer deeth v Depertment of Health and Mental Hygiene. Important: If them 27 is merked other than "natural", or frems 23s any injury or other traumatic event, the Mental

with the Merylend

Examiner and il-transit the attending physician a ched for use as the buriel-Physician/Medicai signed by t þ been si Completed has certificate funeral director, Be Certification: To this After

The law requires that the death certificate be executed

or Attanding Physician:

Hospital

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death.

24 hours efter death

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Division of Vital Records, P.O. Box 68760,

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 No 2 No

25. Was cese referred to medical examiner? 2 No 1 ☐ Yes 27. Mariner of Death

5 Pending

investigation

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work?

MI

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, State)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Alcunan

32. Registrar's Signature

1 🗐 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

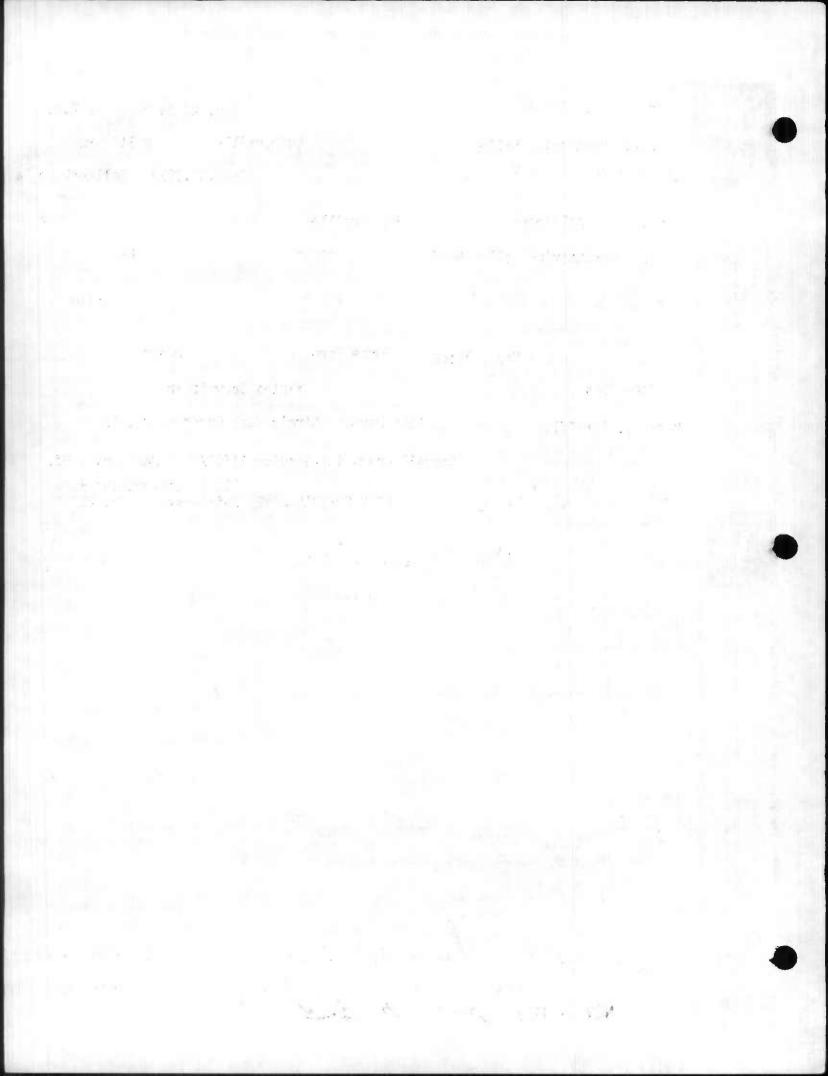
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29d. Date signed (Month, Day, Year)

ed cause of deeth (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Day Year **Physician** Mary L. Brafford November 16, 1999

4b. City, Town, or Location of Death 4c. County of Death 1999 12:00PM /Medical 4a Facility Nama (If not institution, giva street and number) Examiner 26 Pendragon Circle Reisterstown Baltimore If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF Months Days Hours Min. Yrs. Director 563-32-3855 March 29,1929 CA r 28a-f show anotified at 10x State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD 1 Yas 2 No Baltimore Reisterstown Directo 8 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or itsms 23s or the Medical Examiner must be a 26 Pendragon Circle 21136 Funeral USA 12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yas, Giva Year or Datas: 14. Raca - American Indian, Was Decedanl of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Dacadant's Education (Specify only highest grada complated) d 2 should be filed within 72 th and Merital Hygiene. 7 is marked other than "ru Elementary/Secondary (0-12) College (1-4or 5+) Balt. Co. Dept.of Age School Aid 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Amos Brafford Edith Gibson 19a. Informent's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 and 2 st Department of Health and Important: If hem 27 is n any injury or other traus odcs. Craig H. Schroeder 3822 Shiloh Ave., Hampstead, MD Son 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Placa of Disposition (Name of camatary, cramatory or other placa) 20c. Location - City or Town, Stata Data 4 ☐ Donation 5 ☐ Othar (Spacify) Carroll Cremation 11/20/99 Hampstead, MD 21. Signalum To Funeral Service Licenses 22. Nama and Addrass of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD me amo 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Between Onsat and Death Physician /Medical diste Cause (Final Cardiac Assest due to Assythemia Examiner Dua to (or es a consaquanca of) Examine HASCVD. Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events, resulting in death.) Due to (or es e consequance of) physician and street and the street HBP. that the death certificate be Physician/Medical Cause (Disease or inju-that initiated events resulting in death) Last Dua to (or as a consaquanca of): BI TIA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 9 9 signed by d be detacl 1 Yas 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings available prior to 24a. Was an autopsy performad? Completed Deen completion of causa of death? Will 200 N/K. page 2 The 1 Yas 2 No 2 No certificate Physicians 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1□ Yes No Othar: 4□ Nursing Homa 5 Residence 6 □ Othar (Spacify) 10 After this funeral 27. Manner of Death 28d. Dascribe how Injury occurred Certification: 28e. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? VERNatural Attending 5 Pending il or Attendin after death. Director: Aft 1 ☐ Yas 2 ☐ No investigation ≥ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled. Certifying Phyelclan: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) edical 29e, Certifier (Check only and mannar stated. 29b. Signature and title of certifies 29c. Licansa numbar 29d. Date signed (Month, Dav. Year)

State Registrar Dino S. Patel.

1. Date filed (Month, Day, Year) M.D. 32. Registrar's Signature NOV-2-2

MD.

rson who complated cause of deeth (Item 23a) (Type, Print)

Suite 202 Walker Center, 19 Walker Ave., Baltimore, MD 21208

D 28530.

**DHMH 16 Rev 6/95** 

Box 68760

Division of Vital Records, P.O.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 36375 Amended Item29c per FR, G777,11/22/99dhb Certificate of Death 1. Decedenl's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year Physician 6 AM VIVIAN A. BURRELL 11-15-99 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5118 THUNDER HILL HOWARD If Under Birthplaca (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 10 M 20 F Yrs Director 217-16-5166 Usual Residence of Decedant 10b. County 10a Stata 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 10d Inside City Limits 1 Yes 2 No Director MD OWARD OLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 5118 THUNDER HILL RD Funeral 12. Was Decedent Evar in U.S. Armed Forcas?

1 Yes 2 No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Stalus 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 is marked other tha any injury or other traumatic avent, that ones. 12 TH GRADE USTODIAN BALTO. COUNTY OCHOOLS NIA 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BURREL 9 HENRY 4DELAIDE KANE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORSEY KO 5118 21045 ORRAINE HUNDER mo HILL DUMBIA. 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata MEMORIAL PARK 4 ☐ Donation 5 ☐ Othar (Specify) 11-19-99 KANDAUSTOWN MO 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disess Approximale Interval Batween Onset and Death **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed burlal-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a cons and physician P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 980 Part II. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 Unknown 1 Yes 2 No bengis be del Records. by 24b. Ware autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 1 Yas a No certificate 102u of Vital director. Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospital: Other: 4☐ Nursing Homa A Rasidence 6 ☐ Othar (Specify) 1 Yas 25 No 9 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manpar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural
2 Accident 1 ☐ Yas 2 ☐ No

Certification:

5 Pending invastigation

6 ☐ Could not be 3 ☐ Suicida 4 Homicide

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifia: (Check only one) Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certified 1 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D0018847

29d. Data signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signatura

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State Registrar

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Funeral Director

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		State of	of Maryla				Health a		Mental Hy	gien Reg. N	- 0	9	363	76
1. Decedent's Nam Edwar			y, Jr.						2. Dete of De Month NOVEM		<sup>ey</sup> 18,	<u>1999</u>	3. Time o	of Death O AM
		nn, give street and nu ROAD (REA					4b. City, To BALT		ocation of Deat	th 4	c. County	of Deeth		
5. Social Security 1	-5839	6. Sex	7. Age (In yrs 48	. last birthday Yrs.	Months	r 1 Year Deys		24 Hrs. Min.	8. Dete of Bir (Month, Di 07-0			9. Birthpl Count	ece (Stete ry) ME	or Foreign
Usual Residence of			100 0	the Town and	tio-							-		Dia 1 1 14
	10b. County		10c. C	ity, Town or L	.ocation							10	d. Inside C	,
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10e. Street and No.		ceen Ave	nue		10f. Ziş		214			10g. C	Citizen of V	Whet Count	ry?	
11. Marital Status  1 □ Never Married ★★ Married  3 □ Widowed 4 □ Divorced  12. Wes Decedent Eve Armed Forces?  1 □ Yes 2★□ No If Yes, Give Year or Dates:				J,S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1☐ Yes						itc.			
(Spe	15. Deceder	nt's Education		(Giv	edent's Usu	ork done	durina mos	t of work	king	16b.	Kind of B	usiness/Ind	ustry	
Elementary/Sec	ondary (0-12)			Maintenance					C&P Telephor				one	Co.
17. Father's Name	(First, Middle,	, Last)					18. Mothe	er's Nem	e (First, Middle	, Maide	n Sumen	ne)		
Edward		Clay					Ar	nnie	3		Ter	cry		
19a. Informant's N		ship (Type, Print) Clay							ral Route Numb					1111
20a. Method of Dis	sposition Cremation	3 □Removel from	State	Plece of Disp cemetery, cre	osition (Na	me of other ple	ice)		Dete	20c.	Location -	City or To	vn, Stete	
21. Signeture of F	uneral Service	Licensee	~~>			2 1 2 2 2 2			Baltime 1101		-		-	
23a. Part1. Enter shock, or he	the disease, o art feilure. List	complications that a tonly one cause on	ceuson the dou sech line.	Do not er	nter the mod	de of dyi	ng, such es	cerdiac	or respiretory e	errest,			Approxime Intervel Be Onset end	tween

**Physician** /Medical Examiner

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or Attending Physicien:

To the Hospital or Attendir within 24 hours etter deeth, To the Funerel Director: A

The lew requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel hygiene. Important: If I fem 27 is marked other than "natural" and intermedication of the resumetic event.

Examiner Physician/Medical Be Completed by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

SMOKE INHALATION AND THERMAL INJURIES Due to (or es a consequence of): Due to (or es e consequence of): Due to (or es e consequence of):

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2010 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an eutopsy performed? XX Yes 2□ No XX Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 KK ther (Specify) SCENE Medical Certification: To Mes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 11-18-99 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 0530 AM 1 Natural 1 Yes 2\OXNo SELF-IMMOLATION 2 Accident 6 Could not be determined 3 Sticide 4 ☐ Homicide Location (Street end Number or Rural Route Number, City or Town, Stete) 4621 HARFORD ROAD 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) PEP BOYS LOADING DOCK

BALTIMORE CITY, MARYLAND

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated to Hedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the 29a. Certifier ner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified

30. Name and address of person who completed ceuse of death (Item 23s) (Type, Print)

O.C.M.E.

NOVEMBER 18, 1999

5 Stephen S adentz 32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

State Registrar

**DHMH 16 Rev 6/95** 

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death **Physician** Month Year Capers Williams 1842 ,1999 November /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns HOPKINS Salt: more If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 09-07-45 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1 M 20 F 218-42-3304 54 Director MD Usuel Rasidenca of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD NA Baltimore XIXIYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berrie 23s or 21213 2620 East Federal Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes ▼ No If Yes, Give X Never Marriad 2 Married ě Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hosp. Elementary/Secondery (0-12) College (1-4or 5+) 8th Grade NA Animal Service Technician Johns Hopkins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is merked or any Injury or other traumatic eve Delbert Capers Rosa Hannah 10 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1 2 1 5 19e. Informani's Neme/Relationship (Type, Print) Timothy 6511 Parsons Avenue Baltimore, Maryland Capers 20a. Melhod of Disposition 20b. Piece of Disposition (Name of Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Kings Mem. Pk. Cemetery 11-23-99 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21202 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finel Sepsis 10 days diseese or condition resulting in death) Examiner Examiner Sigmoid 3 Weeks Perforated Hospital or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): been signed by the a should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 45 Unknown Records, þ Completed 24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 2 DNO 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient edical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date o'Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: A completely filled in by the fu Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier

Registrar

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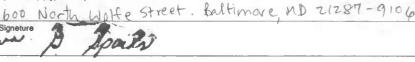
31. Dete filed (Month, Day, Year) State

29b. Signature and title of cartifier

Satitpunwaycha NOV 2 2



IMP



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 18, 1999

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

500 3 6 ADM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Emma Cyzyk 18 1999 5:40 P.M. November /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale FRANKLIN SQUARE 5. Social Security Number 0 6. Sex BALLIMORE HOSPILAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 29F Months Days 218-28-1638 87 Director June 17 1912 Michigan Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits frame 23s or 28s-f show ther must be notified at MD 1 Yes 2 No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Gerries Ave 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien. Bleck, White, etc. filed within 72 hours efter of Hygiene. Therefore their thei 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White É 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: if Item 27 is marked other this
eny Injury or other treumatic event, that Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Mekolon Mary Brodowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John Cyzyk /husband 404 Gerries Ave Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 22 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Lutheran Cem. 1999 Baltimore, MD 22. Name end Address of Fecility
Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 7110 Sollers Point Rd 21222 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete. Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY INSUFFICIENCY
Due to (or as a consequence of): O DAYS Examiner Examine RespiraTory
Due to (or es a consequence of): DisTRESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. A Spiration Preumonia
Due to (or es a consequence of): Physicisn/Medical Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CORONARY ARTERY Disease, HypoThyRoid is 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? CORONARY ARTERY BYPASS GRAFT Right hip open Reduction, FNTERNAL FIXATION
25. Wels case referred to medical
examiner?

Hospital: A Other: 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Suppatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27 Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural s effer de-al Director: Afr November 3 1 Yes 2 No 4:00 PM 2 De Accident Fell down STEPS 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stefe) 404 GERRIES AVENUE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in ESSEX Home MARYLAND 21221 Continue Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number larco 40819 auma, MD November 18, 1999

State

7

Baltimore,

68760

P.O.

Records,

of Vital

Division or Attending

Registrar **DHMH 16 Rev 6/95** 

30. Name and address of person

31. Date filed (Month, Day, Year)

MARCO ZAMORA

**ORIGINAL** 

Square DR. BAITIMORE, MARYLAND 21221

ompleted cause of death (Item 23a) (Type, Print)

9000 FRANKlin

32 Registrac's Signature

while is a proper to the state of the state

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** COTHORN JOHN October 10, 1999 10:50 am /Medical 4e Fecility Name (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner N/A 3718 Parkfield Road Baltimore If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months 180 M 2□ F Days Hours 89 Yrs. 215-16-7341 Director May 12, 1910 Usual Residence of Deceden the Maryland 10a. Stata 10h County 10c. City. Town or Location 10d. Insida City Limits Hem 27 is marked other than "natural", or hama 23a or 28a-f ahow other traumatic evant, the Moucal Examiner must be notified at 1☐Yes 2☐No Director N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours after death with 1 Deportment of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural", or Items 23a or 3 any injury or other traumatic evant. 21208 USA 3718 Parkfield Rd Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 13. Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yas 2 € No Specify: Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda com Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown Principal Education 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Amanda C. Cothorn Lee Andrew Davis 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 3718 Parkfield Rd Baltimore, MD Shirley Cothorn/niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State N Donetion 5 ☐ Other (Specify) Figurature of Foreral Roylea Licenses. Wade, Director 22. Name and Address of Family Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Renal Failure 6 WKS Examiner Prostati Examiner physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Physician/Medical Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 252 No 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings evailable prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No or Attending Physician: efter death. Diractor: After this certific 25. Wes case referred to medical exeminer?

1 \( \text{Yes} \) Yes Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours e Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the best of exemination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end mannar stated. 29a. Certifier Medical (Check only one) To the To the To the 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. Licanse number 7 aucot mo 00050414

State Registrar

31. Date filed

N-Aucott 10755 Day Year 1999 32 Registrer's Signeture G.

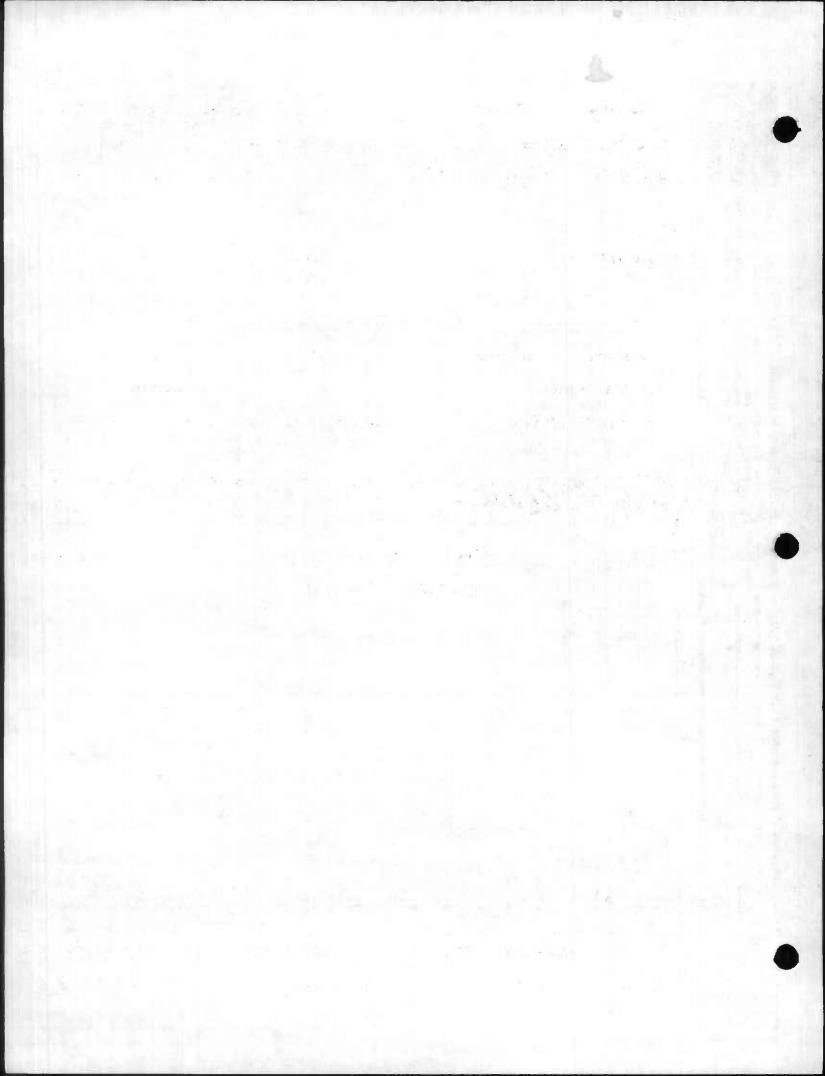
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

10755 Falls RD, we thenville, MD 21093 neture B. Sparks

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Flbert Cassell Cordle November 9:15 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, June 19 9. Birthplace (State or Foreign **Funeral** Virginia 63 227-44-1070 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Essentian must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8361 Lock Wood Road 21122 USA Funeral deeth Wes Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

1 🖄 Yes 2 🗆 № 53 – Year or Detes: 1957 14. Race - American Indien, Bleck, White, etc. 11 Marital Status filed within 72 hours after Hygiene. ther then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Haalth end Mental Hygient Important: if flem 27 is marked other tha any Injury or other traumatic event, the 1 once. Tractor Trailer Truck Driver 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Hugh T. Cordle Myrtle Cordle 19b. Mailing Address (Street end Number or Rurat Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Beverly A. Cordle (wife) 8361 Lock Wood Rd. Pasadena, MD. 21122 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Nov. 22 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Maryland Veterans Cemetery Crownsville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 1999 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licens Stallings Funeral Home, P.A. 3111 Mountain Rd. Pasadena, MD. 21122 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Month disease or condition resulting in deeth) Examiner Gastoustory tube Examiner post attending physician and for use as the bunal-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Due to (or as a consequence of Physician/Medical Due to (or as a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown á should be det Records. þ 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 3 00 1 ☐ Yes 2 ☐ No certificate Division of Vital at or Attending Physician: The state death.

In Director: After this certificate of in by the funerel director, pa Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 XER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 120 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D40519 11-18-99 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 7845 OAKWOOD PROFESSIONAL BUILDING, Suite 200, Chen Brand MIRZA M. MUSAIREG 31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

11-20-99 J.A. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE 11-20-99 0.... REGISTRAR AMEND#20a-c PER F.H.G777 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1999 Reed Colchagoff October 28 5:20 pm 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign WXM2 F DAYS Hours MIN. 56 10-28-99 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Greater Baltimore Medical Center Towson Baltimore RESIDENCE OF DECEDENT 10s STATE 10h COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Glen Burnie permit. 1 YES 2 NO FUNERAL 104 STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit b burial, cremation, or removal. 303 D Mountain Ridge 21061 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, Whits, stc. If yes, specify Cubsn, Maxican, P

1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY TION most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) None None None None once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE Colchagoff Robin E. Burngardner 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 CHILGOAT (STAFF 6.B.M.C., 6701 N. CHARLE Page 6 may be r 21204 TOWSON. MD. pe 20a. METHOD OF DISPOSITION
1 □ Burlal 2X□ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 28c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY BACTIMORE, MARYLAND 21202 10-30 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HOUS. JENKINS SONS hours after death. YORK 4905 RD BALTO,140 21212 medical 23. PART I. Enter the diseasea, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory erreat, Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death the diseese or condition Incompetent Cervix event. resulting in death) 3 weeks QUE TO (OR AS A CONSEQUENCE OF): executed traumatic Spontaneos Rupture of Membranes same day CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 9 if any, leading to immediate the attending physician Mental Hygiene prior to requires that the death certificate be e. Enter UNDERLYING 22 week gestation Inmature Fetus same day other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF that initiated events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL been signed by the any COMPLETION OF CAUSE 1 TES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [3] PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item HOSPITAL:
1% Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 YES 2 1 NO ng Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide hours after d 90 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide datarmined 28 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atsted. HOSPITAL FUNERAL within 72 = TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE obent? Octavely up 10/28/99 2 D31272 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 6701 St. Towson Maryland 21204 Robert E. Ottenritter, M.D. N. Charles 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 2 2 1999 Sparke

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DHMH 16 Rev 6/95

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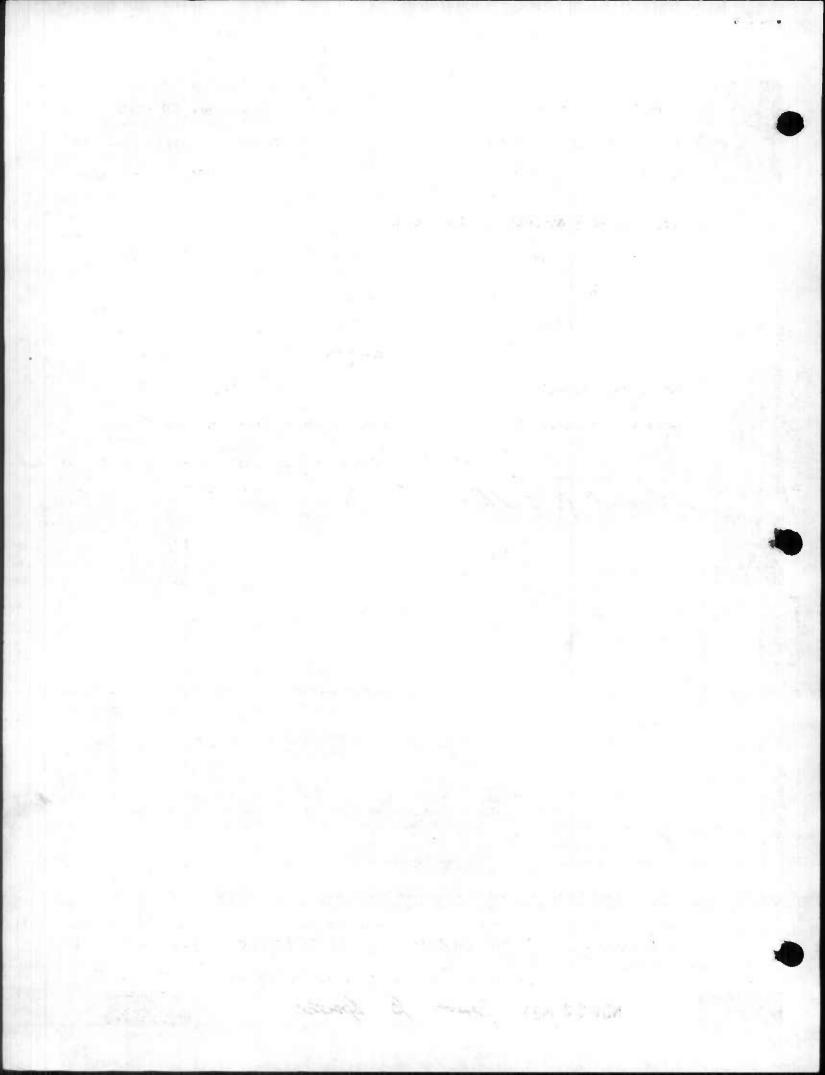
ANNE

MUN S & GAB S & CANA

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1	. Decedent's Name (First, Middle, L	est)		Cer	tificate	of Death	7	2. Data of De	Reg. No.	9	36383
ician dical		Ruth Denn						i	Month	Day 20 /	Yeer 999	3.03A
niner	4	a. Facility Nama (If not institution, g Voeth Arunde							ocation of Daath			
al					last birthday)	If Undar 1		P 24 Hrs.	8. Date of Bird (Month, Da	Anne		ANGE   plece (Steta or Forei ntry)
or		220-18-4144	1 □ M 2XQXF	74	Yrs.	Months D	ays Hours	Min.	9/4/19	y, Yee <i>r)</i> 925	Coul Mary	
	-	Usuel Residence of Decedent 0e. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limit
ţ		Maryland Anne A	rundel	G1e	n Burn	ie						1 ☐ Yes 2 🕅 N
Sirec	Ī	0e. Street and Number				10f. Zip Co	de			10g. Citizen of	What Cou	ntry?
al		103 Fernglen Ave				2106				U.S.		
by Funeral Director		1. Maritel Stetus  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Wes Daced Armed Ford 1  Yas 2 If Yes, Give Year or Dat	ces? ∑☐ No	11	Vas Deceden f Yes, specify I□Yes 2□	Cuban, Mexica	n, Puerto	ecify Yas or No Rican, etc.)		ck, White,	can Indian, etc.
Completed		15. Decedent's I (Specify only highest g	Education rede completed)		(Give	lent's Usuel O	one durina mos	st of worki	ina	16b. Kind of B		
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Be Co	1	7. Fathar's Nema (First, Middle, Las	it)		поше	emaker	18. Moth	er's Name	(First, Middle,	Maiden Suman		
ToB		Maximillion Mann	ie1				Ma	ry	Maye	r		
		9a. Informent's Name/Reletionship	(Type, Print)		19b. Meilin	g Address (S	treet end Numb			er, City or Town,		
		James Emmett Der	ney (Hus				en Aven		T	rnie, MI		
	-	1 X Burlal 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec		lale	Piace of Dispo- cemetery, cren				1/23			
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w	l r	esulting in deeth) Last		Due to (c	os a consequ	defice of ).						
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atlo		1 Naturel 5 Pending investigation	on	Dey Yaer)	Injury	М	1 Yes 2	No				
Certification:		3 Sulcida 6 Could not l 4 Homicide determined	286. Piece o	f Injury - At h g, etc. <i>(Specil</i>	ome, ferm, stre	et, factory, of	fice	4	28f. Location (5 City or Tox	Streat end Numb m, State)	er or Rura	al Route Number,
edical	2	9a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hyelcien: To the b miner: On the bas end menne	is of examine	owledge, deeth stion end/or Inv	occurred et ti estigation, in	ne time, dete en my opinion, dee	nd plece, e eth occurre	end due to the ded et the time,	ceuse(s) end me date end plece,	enner es s end due te	teted. o the cause(s)
Ž	25	9b. Signetura and title of certifier	House		101		cense number			29d. Date signe	d (Month,	Dey, Year)
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		Neme end eddress of person who	completed cause	of deeth (Iter	n 23e) (Type, F	Print)	GIFAI	BUR	NIC	MP	21	861
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DHMH 16 Rev 6/95



State Registrar

O.C.M.E.

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111 Penn Street, Baltimore, Maryland 21201

NOVEMBER 18, 1999

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32. Registrar's Signature

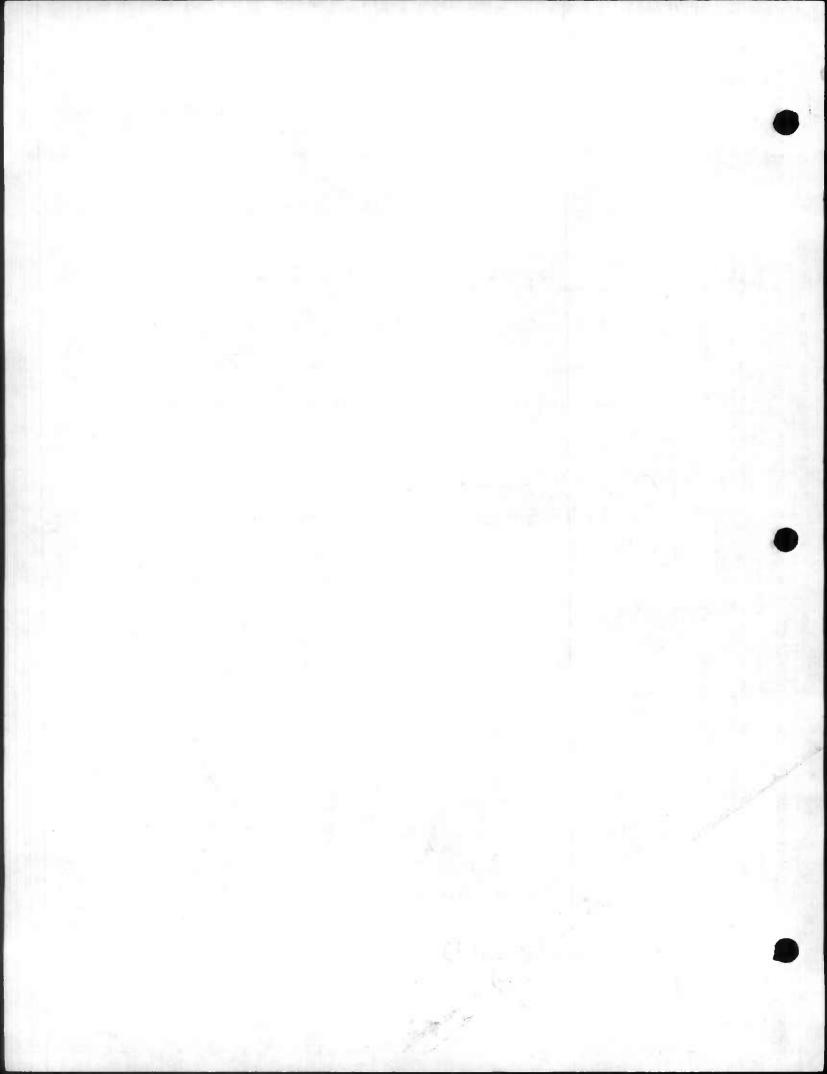
Geneva

d address of person who completed cause of death (Item 23a) (Type, Print)

XXE, My

Row

31. Date filed (Month, Day, Year)



#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Shirley Derr /Medical 4a Facility Name (If not institution, give street and number, 4b. City Town or Location of Death 4c. County of Death Examiner N/A 05 gines MOVE If Under 24 Hrs. 8. 5. Social Security Number ff Under 1 Year Birthplace (State or Foreign Country) NY (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2√2F 75 057-18-0687 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rait, or items 23s or 28s-f show Examiner must be notified at ∜□ Yes 2 □ No Director MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR622 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after or nent of Health and Mentel Hygiene. ant; if fern 27 is marked other than "natural", or her ury or other thaumate event, the Medical Energing. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: White aitimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Secretary Public Relations 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Block Charlotte Gimbel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai 719 Maiden Choice Lane HR622, Baltimore, MD Earl Derr/husband 21228 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade Direction of Funeral Service Licensee Ronald S Wade D Ronald S Wa 22. Name and Address of Fecility Board 655 W. Baltimore Street Director 21201 Baltimore, MD a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediale Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the deeth certificate be exec Physician/Medical Due to (or es a consequence of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sate has been signed to page 2 should be dete þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy 2 NO 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation After 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide an 24 hou. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29e. Certifier

the th

P.O. Box 68760

Vitai Records,

State Registrar

(Check only one)

29b. Signature end title of certifier

30. Natine end eddress of person who

ver 32. Registrar's Signature 1999

(Item 234) (Type, Print)

29c. License number

nd/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

within 2

HAM

99-6938-005

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ryland /	Department of	of Health and	Mental Hygiene	
		4 - 44		0

KIRK EDWARDS		State of Maryland	I / Department of I Certificate of		ital Hygiene	36206
Physician	Kirk Anthon	y Edwards		2.1	Data of Death Month Day IOVEMBER 18,1	3. Time of Death 999 3:36P.M.
/Medical Examiner	4a Englis Mana //f and institution at an			4b. City, Town, or Location Baltimor	on of Death 4c. County	of Death
Funeral Director	5. Social Security Number 6. Sex 220-60-4248 x1x	7. Age (In yrs. la	st birthday) If Under 1 Year Months Days	Hours Min.	Date of Birth Month, Day, Year) 0-02-58	Birthplace (State or Foreign Country)     MD
Maryland a-f show tried at	Usuel Residence of Decedent  10a. Stata  10b. County  MD  NA		Town or Location	7		10d. Inside City Limits X XXYes 2 □ No
ter deeth with the Marylan ter deeth with the Marylan them 23s or 28s-1 show the mart be notified at	10e. Streel and Number	ment Street	10f. Zip Code 212	205	10g. Citizen of V USA	What Country?
D20 D20 D20 D20 D20	11. Merital Stetus  **Thever Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedent Evar in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Datas:	. 13. Was Decedent of If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:		e - American Indien, k, White, etc.
d within piene.	15. Decedent's Educ (Specify only highest grede Elementery/Secondery (0-12) 12th Grade	completed)  College (1-4or 5+)  NA	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Maintenar	during most of working ad)	77.5	out of Home
faryland 2 should be file and Mentel Hy le marked othe sumatic event To Be C	17. Father's Nema (First, Middla, Last)  Donald Go  19e. Informent's Neme/Reletionship (Type)	arland De, Print) Wards		Barbara t and Number or Rural Rd	rst, Middle, Maiden Surnan Edw oute Number, City or Town,	
Ore, ges 1 en of Heal	20e. Method of Disposition  X Burial 2 Cremation 3 Re 4 Donetion 5 Other (Specify)	20b. Pla	ce of Disposition (Name of metery, cremetory or other pleshell Mem. C	oce) D	ate 20c. Location -	City or Town, State ndalk, MD
Baltime permit. Pag Department Important: It any injury o	Signature of Funeral Service License     Pert1. Enter the disease, or complice shock, or heart failure. List only on	14ms	WM . C . Mar	ch FH 110	1 E. North	Approximete
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	Gurst			od and	Interval Between Onset end Death
death certificeta be executed eath certificeta be executed of the for use as the bunal-trensit sticlar/Medical Examiner	Cause (Disease or Injury thet initieted events resulting in deeth) Last		es a consequence of):			
P.O. BOX 6 et the death certific d by the attending p etached for use as	Pert II. Other significant conditions conf	ributing to death but not result	ing in the underlying cause gi	ven in Pert I.	23b. Did tobacco use co	ntribute to the cause of death?
bed by					1□ Yes 20 No	3 Probably 4 Unknown
The lew requires The lew requires age to should be Completed by					24a. Wes an eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
VItal Iclan: The sector, pa	25. Wes case referred to medicat	ospitel: 1 ☐ Inpatient 2 ☐ E	Biomatical all post Ot	26. Place of Deeth (C)		1 Local SCENE
Attending Phore of deeth.  ector: After this by the funeral iffication:	27. Menner of Deeth  1 Neturel 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Day Year)	ne, ferm, street, fectory, office	y at 28d.   28d.	5 Residence 6 Ooth Describe how injury occur  Location (Street and Numb City or Town, State)	81st
Hospit 24 hour Funer stely fill		clan: To the best of my knowler: On the besis of examination and menner stated.				
To the within 2 To the comple	29b. Signe we end title of certifier	volend	29c. Licen	c.M.E.		d (Month, Day, Year)
()	30. Neme and address of person who con	npleted cause of death (Item 2	23a) (Type, Print)	Otronat Dal	timoro Mary	rland 21201

DHMH 16 Rev 6/95

State Registrar

J. J. M.

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month NOVEMBER **Physician** ARNOLD EDLAND 16, 1999 12:50 AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 20 F 212-07-8400 Director JUL.11,1918 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits The Maryla 1 Yes 2 No Director 28e-f BALTIMORE BALTIMORE 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? b 6930 BROOKMILL ROAD #T-1 21208 238 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Hygiene. ther than "natural", or ther ant, the Medical Examines filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 WWII 1 ☐ Yes 2 X No Specify: WHITE Specify: py 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PROPRIETOR FURNITURE REFINISHING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental SAMUEL EDLAND MARY BESELL 19a, Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a if them 27 is or other tra-BARRY EDLAND / SON 8917 MOUNTAINBERRY CIRCLE - FREDERICK, MD 21702 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removal from State Department of Important: If any Injury or 11/18/99 MD VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 21. Signature of Funeral Service I 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the Due to (or as a consequence of): USB BS Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably ate has been signed pega 2 should be de Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy neclormed? 28 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Tyes 2 No 1 Inpatient 25 ER/Outpatient 3 DOA this funerel 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical completely i within 2 To the I \$

Registrar **DHMH 16 Rev 6/95** 

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 2 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signa

29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene QQ

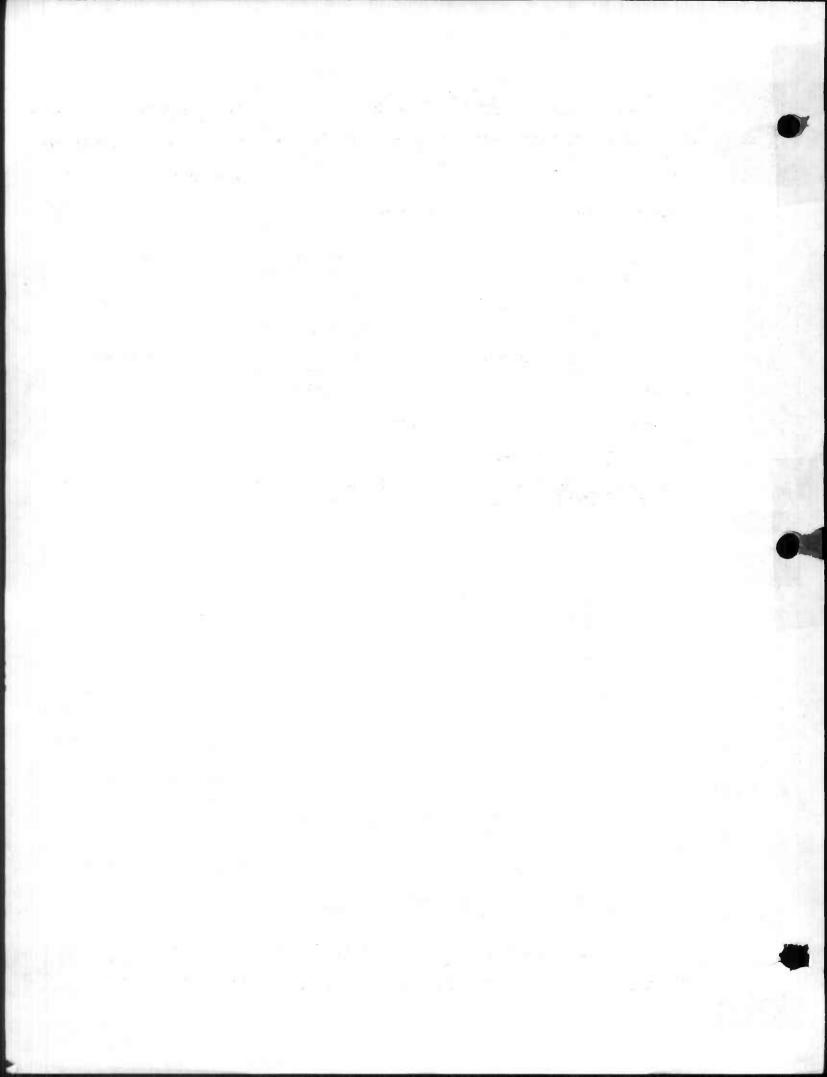
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				Certificate of	Death		Reg. No.		0000
	Physician	1. Decedant's Nama (First, Middle, La				2. Data of De	ath Day 05	Yaar	3. Time of Death
	Physician • /Medical	ISAAC A.	ECKARI	7				Yaar	6:15 Am
	Examiner	4a Facility Name (If not Institution, gir			4b. City, Town, or Lo				->1
		BALTIMONE VE	• • • • • • • • • • • • • • • • • • • •		2 ALTIMO	_	BALTM		
٠	Funeral Director	234-46-6992	Sex 7. Age (In yrs.	8 Yrs. Months Days	s Hours Min.	(Month, Da Dec. 2	7, 1930	9. Birthpi Count Ch	laca (Stata or Foraign etry) arleston,
	P	Usual Rasidenca of Decedant  10a. State 10b. County	10c. Ci	ty, Town or Location				11	0d. Inside City Limits
	Maryd Hatha Bed a	VA Rocking	ham Har	risonburg					1 ☐ Yes 2/☐No
	with the Maydar a or 28a-f show the notified at Director	10e. Street and Number		10f. Zip Coda			10g. Citizan of V	Vhat Coun	itry?
	23a 23a Call	Route 6 Box 209			801		USA		
020	urs after death with the Marylas If, or flame 23s or 28s-f show Darrion must be notified at by Funeral Director	11. Marital Status  1XXVavar Married 2 Married 3 Widowed 4 Divorced	12. Was Dacadant Evar in U Armed Forces? 1 Tyas 2 No If Yes, Giva 1 - 23 - Yaar or Datas: 2 - 25		Hispanic Origin? (Spe ban, Maxican, Puarto I Specify:	cify Yas or No Rican, etc.)	Specify	e - America ok, Whita, a r: W	
2-0		15. Decedant's E	ducation	16a. Decedant's Usual Occi	upation a during most of worki	na	16b. Kind of Bu	sinass/Ind	dustry
121	ed within 72 ho ygiene. er then "neturn r, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Giva kind of work don lifa. DO NOT use retir			Doofi.	C.	
12		17. Fathar's Nama (First, Middla, Last	n	Self Employ	18. Mothar's Nama	(First Middle	Roofin		mpany
lan	de de de de de de de de de de de de de d	Jobe Eckard	,		Mary Ja			ω,	
Maryland 21215-0020	d 2 shou th and M of is man treumen	19a. Informant's Name/Ralationship Ethel V. Fink -	Type, Print) - Friend	19b. Mailing Addrass (Stree Route 6 Bo	et and Numbar or Rura			Stata, Zip	Code)
Baltimore,	Pages 1 ar ent of Hea ht: If them 2 y or other	20a. Mathod of Disposition  1 🛱 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from Stata	Placa of Disposition (Nama of camatery, cramatory or other plast Lawn Mem. (	ardene	Data	20c. Location -		rg, VA
Balti	pemil. Pa Departmen Important any Injury anse.	21. Signature of Frineral Service Lice		_	ress of Facility Funeral Se				
		23a. Part 1 Enter tha disaasa, or con show or heart failura. List only	polications that caused the dea		Hwy Falls			22046	Approximata Interval Batween
	Physician /Medical Examiner  Examiner  Examiner	Immadiata Causa (Final disease or condition rasulting in death)  Sequentially list conditions.	b. RENAL (	or as a consaquanca of):  2ELL CANC or as a consaquanca of):		HILLIR	E		Onset and Death
68760,	incate be g physicia as the bur Aedical	Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last	cDua to (c	or as a consequanca of):					
Box	th cell tendir or use		d					1	
P.O. E	v requires that the death certi been signed by the attending should be deteched for use a leted by Physician/M.	Part II. Other significant conditions of	contributing to death but not ras	sulting In the underlying cause of	given in Part I.			ntribute to	tha cause of death?
	igned be de					4			
Records,	The law requir					24a. Was perfo	an autopsy ormed?	ava	ere eutopsy findings ailable prior to mplation of causa
Rec	has t ge 2 s						-/	of e	death?
	certificate h rector, pege					10		1	Yes 2 No
Vit	sician s certifi director	25. Was casa rafarred to medical exeminar?	Hospital:		26. Place of Death				
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To the Hospital o within 24 hours of To the Funeral Dominately filled in	and the same		29a. Cartifiar 1 Certifying Physical Check only one) 1 Medical Examir	nician: To the best of my knowner: On the basis of axaminat and manner stated.	vledga, ion and	daath occurred or invastigatio	at tha tir n, in my o	na, data and place plnion, daath occ	e, and dua to the urred at tha tima,	causa(s) and ma data and place,	nnar as stated. and dua to tha caus	sa(s)
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		1	30. Name and addrass of parson who co	mplatad causa of death (Item	3a) [	ype, Print)	711/	De D	Correct	ion. I	uting	A .
Red	State	7	31. Data filed (Month, Day, Year) NOV 2 2 1999	62. Registrar's Signa	wel.	Spar	Ks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Neme (First, Middla, Last) 3. Time of Death 2. Deta of Death **Physician** Jack Glenn Frank 8:00 A.M. November 21, 1999 /Medical 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) April 20, 1935 Birthplace (State or Foraign Country) 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Aga (In yrs. last birthday) **Funeral** Days Hours Yrs 216-32-9101 64 Director Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f ahov the Medical Examiner must be notified at 1 Yas 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2 11 Cedar Hill Road 21133 United States Funeral 14. Race - American Indien, Black, Whita, atc. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 🛣 No If Yas, Give Yeer or Deles: 1 ☐ Never Married 2 X Married 8 Maryland 21215-0020 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 1 Department of Heeith and Mental thygiene. Important: if item 27 is marked other than "y any fijury or other treumatic avent, in a Had Binds. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12th Grade -0-PBX Telephone Installation 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Adolph Frank 2 Grace Glenn 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Cedar Hill Road; Randallstown, Maryland 21133 Mrs. Evelyn Frank - Wife 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 □ Cremation 3 □ Ramoval from Steta 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 11/24/99 Sykesville, Maryland 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. J. 8728 Liberty Road; Randallstown, Maryland 21133 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset end Death Physician /Medical CANCEN ears Immediela Cause (Final 001 disaese or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Records, 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 a has 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was casa refarred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) H35P1 & 1 Yes 2 No 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Attanding 5 Pending invastigation 1 Natural 2 Accident s after de. 1 ☐ Yas 2 ☐ No 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Mospital or A 24 hours after Funeral Direction of the 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. edical (Check only To the To To the Comple 29b. Signature and 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

Mochanes St. Balto. Md 21205

son who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death FLEMING Month **Physician** 5:39 AM JO HN 4a Facility Nama (If not institution, give street end number)
4b Facility Nama (If not institution, give street end number)
4cSpiTAL /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year Birthplace (State or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1FIM 2□ F Months 258-14-5643 80 Director SC Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Insida City Limits the Maryla 1 ☐ Yas 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? "natural", or items 23a or adical Examiner must be r 3330 W. Wilkens Avenue 21229 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②ONo If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian, Black, White, etc. 72 hours after 1 □ Navar Married 2 □ Married 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced Black r than "natural the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) pernit. Pages 1 and 2 should be filled within 1 Department of Health and Merial Hygiene. Important: If Item 27 is marked other than "1 any injury or other traumetic event, the Med Dept. Human Elementery/Secondary (0-12) College (1-4or 5+) Resources 12th Grade Councilor 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fathar's Nama (First, Middla, Last) Henry Frank Fleming Fannie Ben 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2306 Ashe Street Durham, NC 27703 Murray Fleming 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State SC 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State John U.M. Church Cem. 11-23-99 Lynchburg, Donation 5 Other (Specify) Baltimore, Maryland 21202 22. Name and Address of Facility 21. Signature of Kuneral Service Liberate WM.C.March FH 1101 E. North Avenue 23a 1.1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, lock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Daath **Physician** BILATERAL PNEU MONIA /Medical Immediate Cause (Final diseese or condition Examiner CERE BRO VAS CULAR ACCIDENT Physician/Medical Examiner physician and tha bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): attending physigned by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown þ 24b. Were eutopsy findings available prior to 24a. Was an autopsy Completed completion of causa of death? certificate has blirector, page 2 s 1 □ Yes 2 □ No 1 Yes 2 No or Attending Physician: director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: Aftert 5 Pending investigation 1 Natural 1 Yes 2 No death. Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Dire aftar Hospital edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner as steted. 29a. Certifier 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and manner stated. (Check only one)

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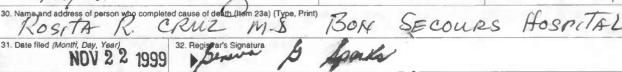
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Registrar

32. Registrar's Signatura

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29c. License number

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29d. Date signed (Month, Dey, Year)

DHMH 16 Rev 6/95

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aminer	4a Facility Name (If not institution, give	a street and number)			4	tb. City, Town, or L		1 1 1 1 1 1 1		
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by Funeral	11. Marital Status  1 □ Navar Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forcas? 1 ☐ Yes 2 ☑ N If Yas, Giva Yaar or Datas:		If Yas, s	cedent of H pecify Cubs	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yas or No- Rican, atc.)		e - Amarican Ind k, Whita, atc. Whit	
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2	G	eorge C. N	Miller			Ag	gnes Cor	rigan		
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o Be	avaminar?	Hospital: 1 ☐ Inpatie	nt 2 ER/Ou	toationt 2	DOA Oth	or:	th (Check only one 5 Pasid		as (Canaihi)	
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edicai C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	raician: To the best of inar: On the basis of and mannar sta	axamination and	, death occurre Vor invastigati	ed at the tin on, in my o	ne, data and place pinion, daath occur	, end due to the c rred at tha tima, c	ceuse(s) end me data and place, a	nner es stated. and dua to tha c	ausa(s)
	29b. Signature and title of swillier	. 1	1	2	29c. License	e number		29d. Data signed	d (Month, Day,	Year)
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ental Hygiene

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0200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Earth har must be notified at BAGS.	To Be Completed by Funeral Director	1
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Baitimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If Itam 27 Is marked other than any injury or other traumatic avant, the MDGs.		2

**Physician** /Medical

Examiner

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certificate

After this funeral

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Box 68760,

Records, P.O.

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Decedent's Neme (First, Middla, Last) Month Day 1999 Raymond Anthony Faidley NOV. 16, 2045 PM Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death GREENMOUNT AVENUE & 24TH STREET BALTIMORE N/A If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Feb 26, 1979 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foraign Country) Months Days Hours 12 M 20 F Maryland 20 Yrs. 214-02-1248 sual Residence of Decedent 10d. Inside City Limits Oa. Stata 10b. County 10c. City. Town or Location 1 Yas 2 No N/A Baltimore Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21213 1729 N. Washington Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc.

1 Yes 2 No Specify:

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ê No If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11

Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry N/A Unemployed

Tyrone Recardo Faidley, Sr. 19a. Informant's Name/Reletionship (Type, Print)

Mrs. Sheila Faidley-Mother

1 Nevar Married 2 Married

17. Father's Name (First, Middle, Last)

20a. Mathod of Disposition

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1729 North Washington Street, Baltimore, MD 21213

Data Nov 23

1999

18. Mother's Nama (First, Middle, Maiden Sumama)

Sheila Hoggard Faidley

20b. Place of Disposition (Nama of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Voshell Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee d a low

22. Name and Address of Facility
Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Immediata Causa (Final disease or condition resulting in death)

23a. PertT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only one cause on aech line. Due to (or as a equence of:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or es a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

20c. Location - City or Town, Stata

Baltimore, MD

24a. Was an autopsy performed? 1 Yas 2 □ No 24b. Ware eutopsy findings available prior to completion of cause of death? 1 des 2 □ No

Approximata Intervel Between Onset and Death

25. Was case referred to medical axaminer? No Yas 2□ No 27. Manner of Death

1 Netural

2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury Month, Day Year) 28b. Tima of Injury

28c. Injury at Work? 1 Yes 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Homa 5 Residence MOther (Specify) AT SCENE 28d. Describe how injury occurred NO U D 0

6 ☐ Could not be detarmined 3 ☐ Suicide 4 Homicide 29a. Certifier

Face of Infury - At hom puilding, etc. (Specify) 2035 - At home, farm, street, factory, office Greenmound ree

281. Location (Street and Number or Rural Route Number, Location (Street and Number or Rural Route Number, N 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data end place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and plece, and dua to the cause(s) and manner stated.

5 Pending investigation

29c. License number O.C.M.E 29d. Data signed (Month, Day, Year) NOV. 17, 1999

rass of person who completed cause of death (Item 23a) (Type, Print) ARONLOC Mi

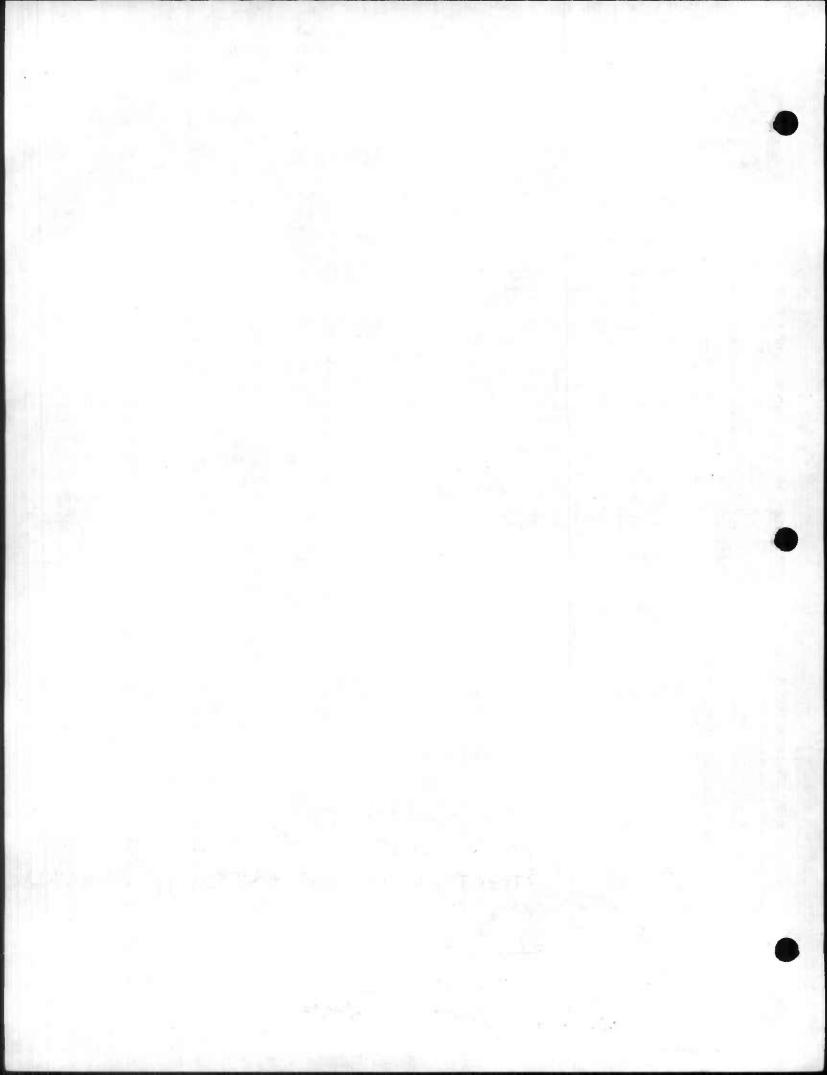
111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signatura reper

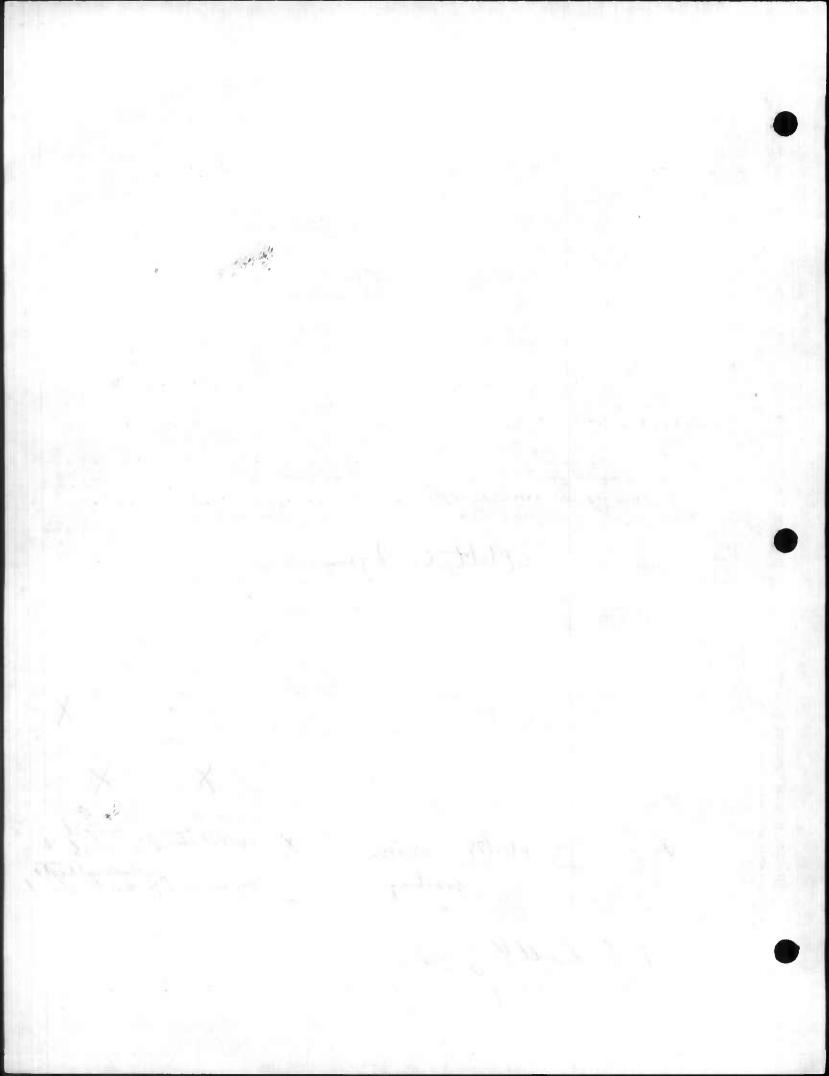
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State of Maryland / Department of Health and Mental Hygiene Q Q 3 5 3 0 1

				O O I IIII O C	ne or i	Death		Reg. No.		
	1. Decedent's Name (First, Middle, L	Last)					2. Date of D	eath		3. Time of Deat
Physician		Edgar A	• Fend1	ay			Novemb	er 16	Year 1999	07:45 H
/Medical Examiner	4a Facility Name (If not institution, g			-	4	lb. City, Town	, or Location of Dea			07.10
Lxammer	Nort	h Arundel H	lospita:	1		Glen	Burnie	Anne	Arur	ndel
uneral			(In yrs. last bir	thday) If Und	er 1 Year	If Under 24	Hrs. 8. Date of B	irth		lace (State or For
irector	218 56 2497	1₩ 2□F	48	Yrs. Month	s Days	Hours	Min. (Month, D April	23,1951		(1) (land
2	10a. State 10b. County		10c. City, Tow	n or Location					11	Od. Inside City Lin
ar ehe	Maryland Anne A	rundel	Pasad	lena						1 ☐ Yes 2)K)
to be notified.	10e. Street and Number 1260 Rock Hill	Road		10f. 2	Tip Code 2112	2		10g. Citizen of U.S		try?
2 2	11, Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dec			? (Specify Yes or N		ce - Americ	an Indien,
natural, or hams 23a or 28a-f show odeal Examiner must be notified at eted by Funeral Director	1 Never Married 2 Married 3 Widowed 4 XDivorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	o			Specify:	? (Specify Yes or Nuerto Rican, etc.)	Specif	ck, White, of Wh	ite
"natural", adical Exe leted by	15. Decedent's	Education	16a.	Decedent's Us (Give kind of a	ual Occup	ation	working	16b. Kind of B	Susiness/Inc	lustry
ten 27 is marked other than "nature other traumatic event, the Medical To Be Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5-	+)	Cleaner	use retired	)	normany	Carp	et	
SE O	17. Father's Name (First, Middle, Las	st)	1	OTCOLIC		18. Mother's	Name (First, Middle			
90 00 00 00 00 00 00 00 00 00 00 00 00 0		John E. Fen	17 a 17				Mildred			
To Tarke	19a. Informant's Name/Relationship		-	PA-W BAA	(0)					0-4-1
							r Rurat Route Num			
om 27 rther tr	Mildred Fendlay  20a. Method of Disposition	/ Mother		260 Roc. Disposition (N		I KOAQ	Pasau	ena, Mar		
mportant: If item 27 iny injury or other to abse	1 Denial 2 Cremation 3 4 Donation 5 Other (Spec		cemete	ry, cremetory of	other plac		k 11/20/9	20c. Location 9 Glen E		
Importu	21. Signature of Funeral Service Lice	ensee '	uh.			ss of Facility		Funeral		
	23a. Part1. Enter the disease or conshock, or heart failure. List only	-correcte	office	1			nway Bal		Ma. Z	1225
ng physicien end eas the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		consequence of						
or us		d								
d by the setached	Part II. Other significant conditions	contributing to death bu	t not resulting is	n the underlying	cause giv	en in Pert I.		Yes 2 No	3 Prot	the cause of dec bebly 4 Unkr
ald be							24a We	s an eutopsy		ere eutopsy finden
beer and								lormed?	COL	npletion of cause
o has been al age 2 should bmpleted							per	lormed?	COL	npletion of cause death?
n g	Of Manager						per	Ves 2□No	COL	npletion of cause
edificate has ector, pege 2 Be Comp	25. Was case referred to medical examiner?	Hospital:	VIII7		Oth	or	Death (Check only	Ves 2□No	of of	res 2□ No
his certificate has il director, page 2 To Be Comp	examiner? 1 X Yes 2 No	Hospital: 1 Inpetier				er: 4 Nursi	Death (Check only	Ves 2 No	her (Specify	res 2□ No
his certificate has il director, page 2 To Be Comp	examiner?	28a. Date of Injun (Month, Pay		ripatient 3   1	OOA Oth	er: 4 Nursi	Death (Check only	Ves 2□No	her (Specify	res 2□ No
ctor: After this certificate has by the funeral director, page 2 floation: To Be Comp	examiner? 1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Nonth, Pay	Year) 28b. Try - At home, to (Specify)	Firme of njury 33 + 12	28c. Injun Worl	er: 4 Nursi	Death (Check only)  Death (Check only)  Death (Check only)  28d, Describe  28d, Describe  28d, Location City or July	Ves 2 □ No one) sidence 6 □Oth how in jury occu (Street and Num own, State)	her (Specify	ropetion of cause death?  Yes 2 No  No ct
ctor: After this certificate has by the funeral director, page 2 floation: To Be Comp	examiner?  1 🖾 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Examine)	28a. Date of Injundenth, Pey La Control on be dependent on the best of the bes	year) 28b. 7y - At home, for (Specify) 7 my knowledge examination an	Firme of njury  3	28c. Injun Word 1 1 2 ory, office	er: 4 Nursi	Death (Check only ng Home 5   Res	Nes 2 □ No cone) sidence 6 □ Oth har injury occu (Street and Num own, State) e cause(s) and m	her (Specify fred Sw ber or Russ thrullu	Position of cause death?  Yes 2 No  No  No  No  No  No  No  No  No  No
ctor: After this certificate has by the funeral director, page 2 floation: To Be Comp	examiner?  1 X Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigate  3 Suicide 6 Could not determine  29a. Certifier (Check only one)  1 X Yes 2 No  5 Pending investigate determine	28a. Date of Injun on be d 28e. Place of Injun building, etc.  Chysician: To the best of	year) 28b. 7y - At home, for (Specify) 7 my knowledge examination an	ime of njury  3 H L  m, street, factor dor investigation	28c. Injun Worl 1 D ory, office d et the tim n, in my of	er: 4 Nursi	Death (Check only ng Home 5   Res	(Street and Number, State)  e cause(s) and m, date and place,	her (Specify Fred Support of Supp	Pres 2 No  No  No  No  No  No  No  No  No  No
he Funeral Director: Atter this certificate has piataly filled in by the funeral director, page 2 edical Certification: To Be Comp	examiner?  1 🖾 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigati 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Examine)	28a. Date of Injundenth, Pey La Control on be dependent on the best of the bes	year) 28b. 7y - At home, for (Specify) 7 my knowledge examination an	ime of njury  3 H L  m, street, factor dor investigation	28c. Injun Worl 1 [] ory, office d et the tim n, in my of	er: 4 Nursi	Death (Check only ng Home 5   Res	Nes 2 No one) sidence 6 Oth how in jury occu (Street and Num own, State) e cause(s) and m o, date and place,	her (Specify rred Such ber or Rujas & Harell La anner as st and due to ded (Month, 1)	Pres 2 No  No  No  No  No  No  No  No  No  No
ctor: After this certificate has by the funeral director, page 2 floation: To Be Comp	examiner?  1 X Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigate  3 Suicide 6 Could not determine  29a. Certifier (Check only one)  1 X Yes 2 No  5 Pending investigate determine	28a. Date of Injundent of the Complete of Injundent of the Complete of Injundent of	ry - At home, (Specify) my knowledge examination and	Time of njury 23 H M M M M M M M M M M M M M M M M M M	28c. Injuny 28c. Injuny Word 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	er: 4 Nursi	Death (Check only ng Home 5   Res	(Street and Num. own, State) e cause(s) and me, date and place, 29d. Date signe	her (Specif) fred Symptom of Symp	Position of cause death?  Yes 2 No  No  No  No  No  No  No  No  No  No



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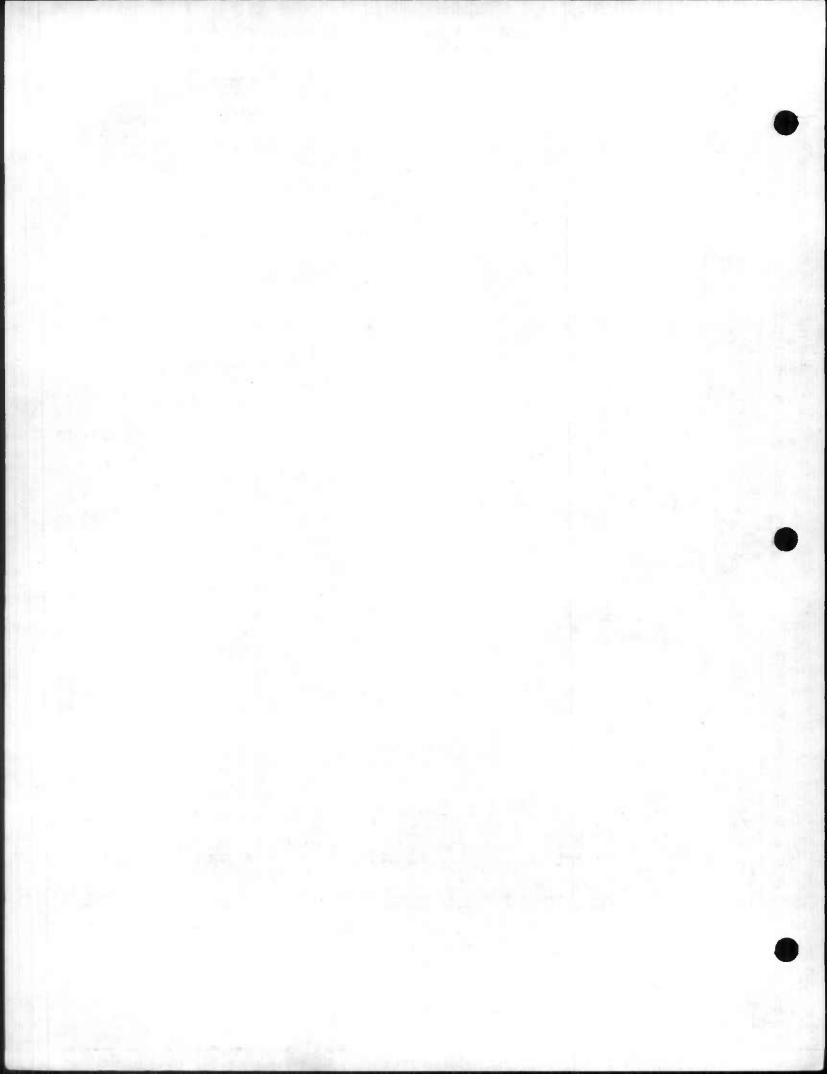
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Month 1840 **Physician** Margaret E. Gray 4b. City, Town, or Location of Death 1999 /Medical 4a Facility Nema (If not institution, give street and number) 4c. County of Death Examiner The Memorial Hospital Easton Talbot Hours Min. 8. Deta of Birth Month, Day, Year) 920 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) unknown **Funeral** Days 1□M 2√2F Months 79 216-34-9962 Director Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. toside City Limits 28a-f show 1 ☐ Yas 2 No Directo Centerville Queen Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21617 USA 205 Armstrong Avenue Nerns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian Black, Whita, atc. 1 Nevar Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or in any Injury or other traumatic event, the Marianian and 1 ☐ Yas 2☐ No Specify: Specify: Black. by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) unknown Elementery/Secondary (0-12) unknown unknown unknown 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Brinkley/friend P.O. BOX 156 Grasonville, MD 21638 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) In State 21. Signature of Funeral Service Licenses. Wade, Director 22 Name and Addrass of Facility Board 655 W. Baltimore Street male Baltimore, MD 21201 234 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examine Examiner physician and the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 Physician/Medical Due to (or as a consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown þ 24b. Were eutopsy findings available prior to completion of causa of daath? Completed 24a. Was an autopsy performed? 1 Yes 2 SHo 1 Yas 2 No or Attanding Physician: 25. Was case raferred to medical axaminar?

1 Yas 2 700 Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 5€2F/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this s 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Medicai Certification: After 1 Netural To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 5 Panding 2 Accidant 1 Yes 2 No 6 Could not ba detarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the causa(s) end menner as steted.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifian (Check only one) 29b. Signature and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) 32036 30. Name-and addrass of person who completed cause of death (ttern 23a) (Type, Print) De Donah Drive Chester MD 21619 rale 31. Data filed 32 Registrar's Signature

State Registrar

**DHMH 16 Rev 6/95** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36396 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 18:1999 12:39am JOHN HAYWOOD. NOU. SR. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GIEN BURNIE NORTH ARUNdel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stete or Foreign Funeral Hours XXM 2DF 216-30-5592 77 Yrs. ALABAMA Director APRIL 4. Usual Residence of Decedent the Meryland 10b. County 10e State 10c. City. Town or Location 10d. Inside City Limits ehow. permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryle Department of Health and Maniel Hyglens. Importants if them 23s or 28e-f ehow Importants if them 25 is marked other than "netural", or itema 23s or 28e-f ehow eny injury or other treumstic event, the Medies Essentse must be notified at 1 ☐ Yes 24 No Director MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 748 EVERGREEN ROAD 21144 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces 1945-Bleck, White, etc. 12 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 27 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE 1946 Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR U. S. GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOHN HAYWOOD **EMMA** O'DONNELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANCES HAYWOOD 748 EVERGREEN ROAD, SEVERN, MD. 21144 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 11/20/99 GLEN BURNIE, MD. ire of Funeral Service Licenson 22. Nama and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrasf, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine 2081 physician and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated manuals) Due to (or see consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peeu 1 Yes 2/2000 Division of VItal 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 10 Certification: To 2 PER/Outpatient 3□ DOA SH 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 28d. Describe how injury occurred After t or Attending 1 [Natural 5 Pending investigation efter deeth.

Director: Aft
d in by the fur 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or Att within 24 hours effer of To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crein Hipfway Wy Vm harles Burnie

**DHMH 16 Rev 6/95** 

Registrar

31. Date filed (Month, Day, Year)

21.6

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtifica	te of	Death		Re	eg. No.	3 30391		
Physicia /Medica	John Ha	rris								2. Date of Deat Month Septem		3. Time of Death 1999 7:17 A.M		
Examine	An English March March Institute		treet and nun	nber)				46. City, To Balt:	imore		4c. County	of Death N/A		
Funeral Director	5. Social Security Number unknown		M 2□F	7. Age (In yrs. 74	last birthday) Yrs.	Months Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, March 2	Year) 5,1925	Birthplace (State or Foreign County)     County)		
Maryland of show fled at	Usual Residence of Decedent 10m. State 10b. Co. Maryland				y,Town or L Baltimo		ity			10d. Inside City Lin V⊡Ves 2 □				
	10e. Street and Number  917 Stoll S  11. Marital Status  112 Never Married 2		10f. Zip Code  21225  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Code Code Code Code Code Code Code Code								Citizen of What Country?  USA  14. Race - American Indian.			
0020 ours after o	3 Widowed 4 Divo	Married	Armed Forces 1  Yes 2   If Yes, Give Year or Dates		Tinknown		<ol> <li>Was Decedent of Hispanic Origin? (Stress, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:</li> </ol>			Rican, etc.)		ck, White, etc.		
Maryland 21215-0020 d 2 should be lited within 72 hours at the and Mental Hygiene. The marked other than "natural", or treumatic event, the Medical Exam	(Specify only his		completed) College (1		16a. Dece (Give life.	kind of w DO NOT i	ork done ise retire	during mos	t of workir	ng		usiness/Industry		
riand 2	unknown 17. Father's Name (First, Mid unknown	de, Last)	unkno	wn.		unk	nown	18. Mothe		(First, Middle, A		iknown e)		
	19a. Informant's Name/Relate	ionship <i>(Typ</i>	e, Print)		111	Pen	nn Street Baltim			imore,	Route Number, City or Town, State, Zip Code) imore, MD 21201			
Battimore, semil. Pages 1 a separiment of Hes mportant: if Itsen my injury or othe bids.	20a. Method of Disposition  1 Burial 2 Cremati 4 Donation 5 SOthe	r (Specify)	in st	State	Place of Dispo cemetery, cre			ce)		Date	20c. Location -	City or Town, State		
Ball Depart Import	21. Signature of Funeral Sen	ndia	S. Wad	e Dire	ector 2			a Comy			. Balt:	imore Street		
Physician /Medical Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition	or complic List only on	e cause on e	erioscl							est,	Approximate Interval Between Onset and Death		
	resulting in death)	- 1		Due to (d	or as a conse	quence of)	•					6 3 5		
58760, cate be executed physician and a the burfal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a consequence of):											
Box 68760, seth certificate be swattending physician effor use as the burial.	resulting in death) Last	La	Due to (or as a consequence of):											
	Part II. Other significant con	ditions cont	ributing to de	eth but not res	ulting in the u	inderlying	cause giv	ren in Part I	l			ntribute to the cause of death?		
Records, P.O. ne lew requires that the shas been signed by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be detached by the second be second by the second by the second by the second be second by the second by the second by the second be second by the second be second by the second by the second by the second be second by the second by the second by the second by the second by the second by the second be second by the										24a. Was as perform	ned?	24b. Were autopsy findings available prior to completion of cause of death?		
= F 50 C											s 2 No	1 ☐ Yes 2 ☐ No		
Of Vital Physicien: This cardificate rai director, pe	25. Was case referred to med examiner?  1 Xyes 2 No		ospital:		lene		Ott	NO.		(Check only on				
4 8 8 1		estigation	28a, Date o	-	28b. Time of Injury		28c. Injui Wo		2	ne 5 🛛 Reside 28d. Describe ho				
Division fai or Attending irs after death. rel Director: After lied in by the fune	4 Homicide del	uld not be lermined	28e. Place buildin	of Injury - At h	ome, farm, st	reet, facto	y, office		2	28f. Location (St. City or Town		er or Rural Route Number,		
	O COMPANY 2 X Medi	cal Examin		sis of examina		vestigation	n, in my c	pinion, dea			ate and place,	and due to the cause(s)		
0 = 0 6	29b. Signature and title of our	tiller _				29	c. Licens	e number		2	9d. Date signe	d (Month, Day, Year)		

31. Date filed (Month Pag Year) 1999 State

J. Laron Locke M.D.

32. Registrar's Signature

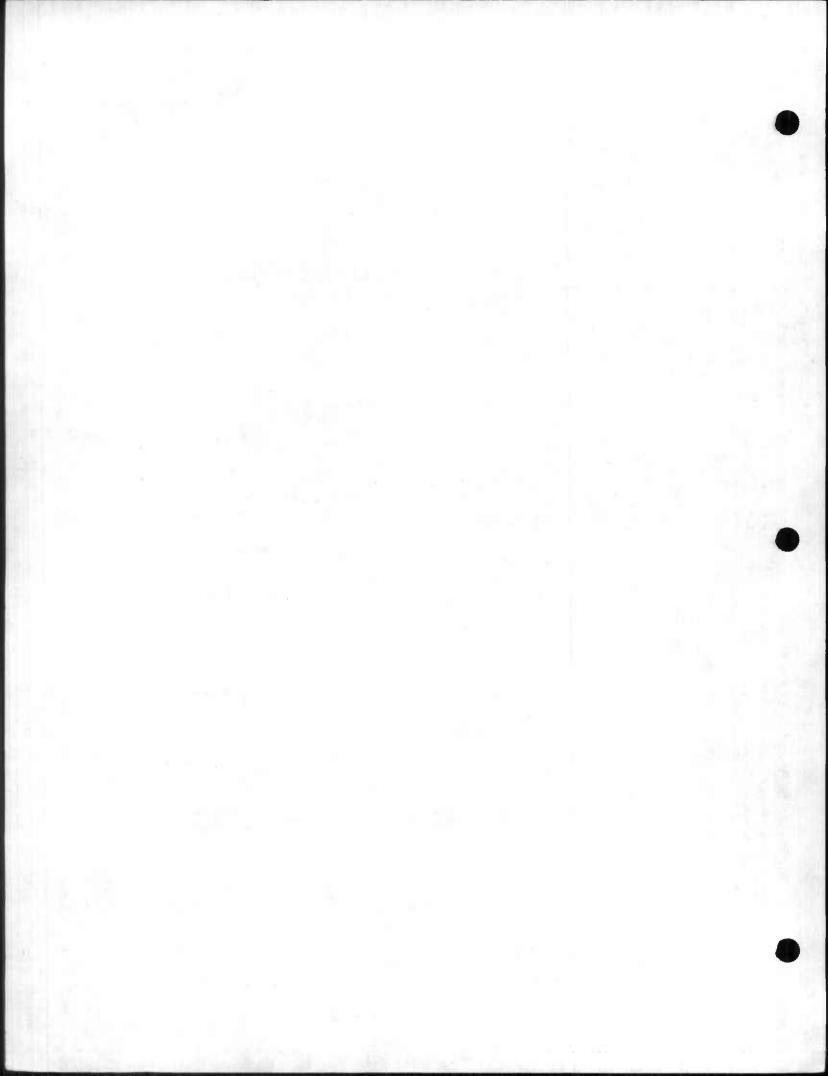
address of person who completed cause of death (Item 23a) (Type, Print)

souls

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

November 15, 1999



State of Maryland / Department of Health and Mental Hygiene 99

6398 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician November 21, 1999 10:10 A.M. Fred India /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, giva street and number) Examiner St. Agnes Nursing and Rehabilitation Cntr. Ellicott City Howard If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplece (State or Foreign Country) **Funeral** \$CHM 2□F Months Days Yrs. Feb. 8, 1910 Romania Director 089-28-2815
Usual Rasidence of Decedent 89 with the Marylend 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 Yas XXNo Director Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21042 Spring Thaw Ct. 10121 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mentel Hygiena. Int: If item 27 is marked other than "natural", or items 23. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian. 11 Marital Status Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 □ Nevar Married 2 □ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3₺ Widowed 4 Divorced White Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 10 Broker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Rachel Unknown Schlmo Zui 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10121 Spring Thaw Ct. Ellicott City, MD. 21042 Jack Indig / son other 1 altimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Novee 23 Burial 2 □ Cramation 3 □ Removal from State 0 Department of Important: if any injury or pace. 1999 Long Island, New York 4 ☐ Donation 5 ☐ Other (Specify) New Montifiore Cemetery 22. Nama and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licensea Know 2 2 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Onset and Deeth **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in death) YR Examiner Due to (or es e consequence of): Examiner HEARI ONGESTIVE physician and the burial-transit the death cartificata be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760 HYPERTEN SION Physician/Medical Due to (or as e consequence of): 80 980 ō signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably M Unknown Division of Vital Records, þ 24b. Were autopsy findings evaileble prior to complation of cause of deeth? 24e. Was en autopsy performed? Completed cartificata has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was cese referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Aftar 1 Natural 5 Pending eftar death. 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours Hospital 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medicai completely (Check only one) To the within 2 To the 29b. Signature and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Yaar) D42680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21042 9051 BALT. WHIL. PIKE SHEIKH m.0 32. Registrar's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. t. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Howard M. Iser NOVEMBER 12, 1999 7:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Hospital Cumberland Allegheny If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dale of Birth (Month, Dey, Year) June 24, 1922 6 Sax 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Days 1√2 M 2□ F 214-68-7095 Yrs. Director Usual Residence of Decedent the Maryland 10a. State t 0b. County t Oc. City, Town or Location t0d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD notifie Allegheny Cumberland 10e. Street and Number t Of. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental hygiens. Important: if Item 27 is marked other than "natural", or Itema 25s or any Injury or other traumatic event, the Medical Examples must be n l Kaylor Circle 21532 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t 4. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No It Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 Yes 2√ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 40-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t5. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (t-4or 5+) 12 Plumber Plumbing t 7. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Newton F. Iser Edna G. Fadley t 9a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) unknown Francis Fuller/sister 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete t Burial 2 Cremetion 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. Wade, Director 22. Name end Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pertt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart lailure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** INGESTIVE HEART FIAILURE Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of):

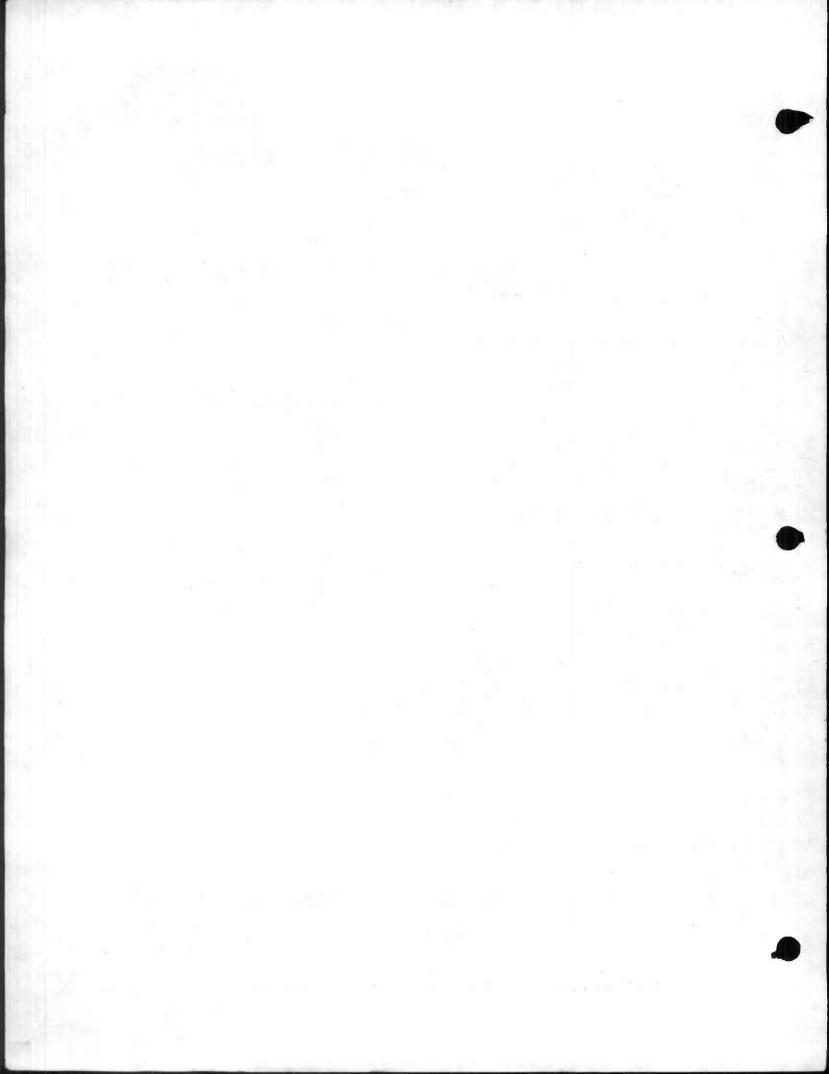
20NARY ARTERT DISCASE EAR Medical Certification: To Be Completed by Physician/Medical Examiner signed by the ettending physicien and i be detached for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. OBSTRUCTIVE USTASZ1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings availabla prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No t ☐ Yes 22 No or Attanding Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) t ☐ Yes 20 No 24 hours after death.

24 hours after death.

25 Funerel Director: After this letaly filled in by the funeral of 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred ty Natural
2 Accident Division 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Hospital to Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner states. 29a. Certifier completely (Check only one) To the Within 2 29c. License number 29d. Dala signed (Month, Dev. Year) 29b. Signature and title of certifier NOVEMBER / , 30. Name and address of person who cop and cause of death (Item 23a) (Type, Print) CHANG OH, M.D. **48 TARN TERRACE** FROSTBURG MD 3t. Date filed (Mooth, Day, Year) 32 Flogistrar's Signature State Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36400 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Roskev Lee Johnson, Sr. 15, 99 10:05pm Nov. 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Ctn. Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) XM 2□F 242-58-6998 NC 05 - 14 - 37Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 4904 Aberdeen Avenue 21206 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, Whita, etc. 1 ☐ Yes X No If Yas, Giva 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: Black 3 ☐ Widowad 4 ☒ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Construction worked Construction Co. 5th Grade 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) White Johnson Carey 21206 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 4904 Aberdeen Avenue Baltimore, Maryland Johnson Renea 20b. Place of Disposition (Nama of 20a Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 11-20-99 Lansdowne, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility altimore, Maryland 21202 WM.C. March FH 1101 E. 23a Part I. Emil the disease, or complications that feased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. WM.C. March FH 1101 E. North Avenue Immédiata Causa (Final disaasa or condition rasulting in death) Metustasis from cuncer Smooth. Dua to (or as a consequence of): mall Sequantially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disaase or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mantal Hygii Important; If Itam 27 is marked other only injury or other treumatic event.

Director

Funeral

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Completed

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the Marylend

Baltimore, Maryland 21215-0020

Physician/Medical signed by t 9 Completed certificate has t lirector, page 2 s Be Certification: To this

P.O. Box 68760 Records, Division of Vital or Attending Physician: After death. after death Director; J

n 24 hours aft e Funeral Di pletely filled in To the Hospital of within 24 hours af To the Funeral Di completely filled is

Registrar

**DHMH 16 Rev 6/95** 

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25. Was casa rafarrad to medical examinar?

29b. Signatura and title of certifier

31. Data filed (Month, Day, Year)

FOR

5 Pending invastigation

6 Could not be

1 Yas 2 No

27. Mannar of Death

1 Matural

2 Accidant

3 ☐ Suicida

29a. Cartifiar

4 Homicida

Moyo 32. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28a. Data of Injury (Month, Day Year)

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

Johns

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

600

1 Yes 2 No

26. Place of Death (Check only one)

N. Wolfe

Hopkins

Other: 41 Nursing Homa 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year)

Ber S S VOV

CLII									
Stuart Johnson				State	of Mar	yland /	Department of Health and Mer	ntal Hygiene 00	261.0
AMEND ITEMS:	#23	PART	I,	27	PER	MEO	Department of Health and Mer Certificate of Death	Reg. No.	3040

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neral ector	214-62-9027		je (In yrs. l. 15		Under 1 Year Ionths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 09-14-	h, Year) -54	Birthplaca (State or Foreign Country)     M D	
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ect and	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?	-
	4638 Marble H	all Road			21239	9		USA	,	
by Fune	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2X If Yes, Give Year or Dates:		If Ye	Decedent of Hes, specify Cube	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.	
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To To	George	Johnson				Carrie				_
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other	Carrie M. F  20a. Method of Disposition	reeman	anh Di	ace of Disposition		nall K				-
9	20a. Method of Disposition  12 Burial 2 □ Cremation 3	☐Removal from Stata	CE	metery, cremate	ory or other place		Date		City or Town, State MD	
len's	4 □ Donation 5 □ Other (Spec	**	Ga						Owings Mills	_
any Injury or once.	21. Signature of Funeral Service Lic	ensee			ame and Addres				cyland 21202	
	Une 8h	AND	_			ch FH 1			Avenue	
	23a. Part1. Enter the disease, or co shock, or heert tailure. List on	mplications that cause y one ceuse on each l	d the death	Do not enter t	he mode ot dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Intervel Between	
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director	examiner 7 1 □XYes 2 □ No 27. Manner of Death	28a. Date of Init			101	10				
director	1 XYes 2 No  27. Manner of Death 1 Naturel 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury					100	
in by the funeral director	1 □XYes 2 □ No 27. Manner of Death	(Month, Da	y Year) ury - At ho	me, tarm, street,	M 1 🗆	Yes 2□No	28f. Location (S City or Ton		per or Rural Route Number,	
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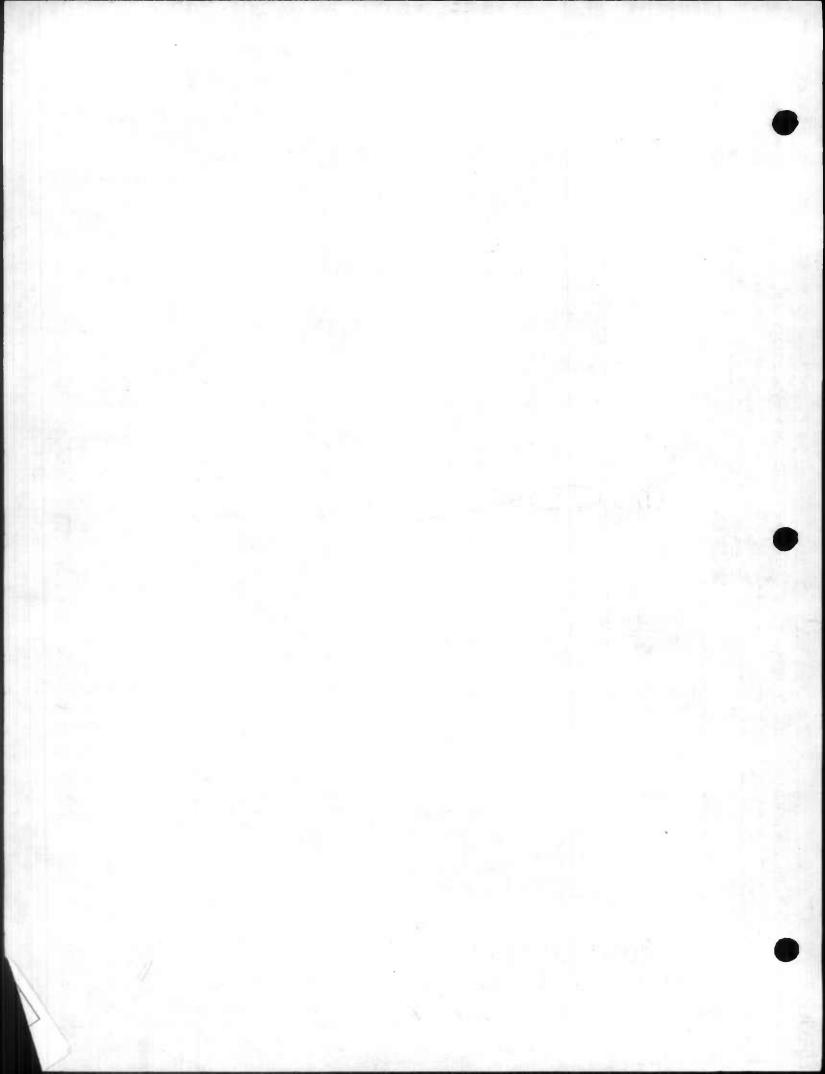
State

DHMH 16 Rev 6/95

Registrar

111 Penn Street, Baltimore, Maryland 21201

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** BERNICE JANNEY NOVEMBER 15, 1999 9:00 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 2 F Months Hours 217-46-0042 84 Director JAN.31,1915 MD Usuel Residence of Decedent deeth with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 No Yes 2 No FL PINELLAS CO. Director ST. PETERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1255 PASADEN AVE. SOUTH #1002 33707 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herna 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, the Medical Esaminer Black, White, etc. filed within 72 hours efter 1 Yes 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify: 21215-0020 ò Specify: Completed by WHITE 3 Widowed 4 ☐ Divorced "naturel" 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) tel Hygiene. Elementery/Secondery (0-12) HOMEMAKER OWN HOME permit. Peges 1 and 2 should be file.
Department of Heelth and Mentel Hyg.
Important: If item 27 is marked other any injury or other traum-18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be MOSES SHAIVITZ ANNA SHULMAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAY JANNEY / SON 3716 BRENTFORD ROAD - RANDALLSTOWN, MD 21133 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 11/17/99 BALTIMORE, MD 21. Signeture of Funerel Sen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel ZmmR disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest buniel-tran and Due to (or es e consequence of): P.O. Box 68760. physician Physician/Medicai the Due to (or es e consequence of) signed by the at d be detached for Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Ibymin emca 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, À 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? hes 1 Yes 2 NA 1 ☐ Yes 2 ☐ No Attending Physician: funeral director. 25. Was case referred immedical Be 26. Place of Death-(Check only one) 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA this Date of Injury 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Meturel 5 Pending investigation 1 ☐ Yes 2 ☐ No efter deeth. 2 Accident the 6 Could not be determined To the Hospital or Atterwithin 24 hours effer der To the Funerel Director completely filled in by the 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 12815 25-Main Nown MASSY/ AND 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) NOV 2 2 State Registrar

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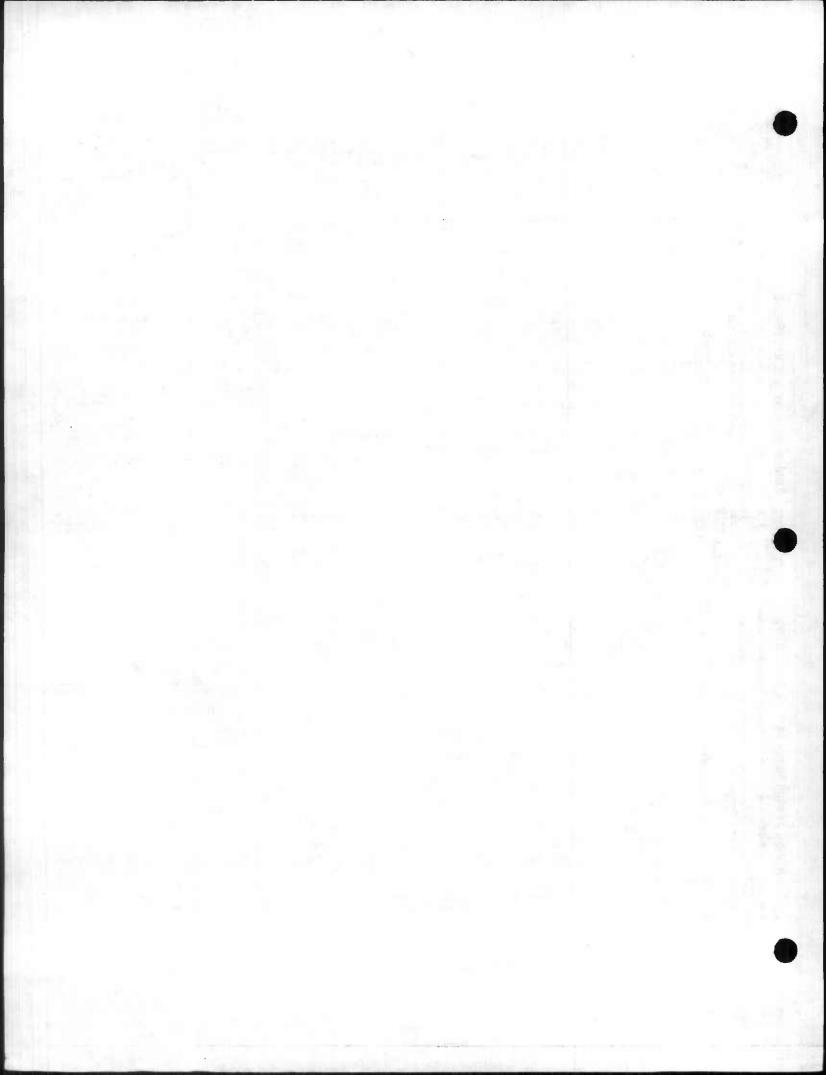
State of Maryland / Department of Health and Mental Hygiene

26-	28f PER M.E.O. G777 1: 1. Decedent's Name (First, Middle, L			Certifica	ate of	Death	2. Dete of De	Reg. No.		5 4 0 3 3. Time of Death
ician	Shimieka	Nic	ole	Jenk	ins		Month	Dey	Year	1 17 D W
dical niner	4a Facility Name (If not institution, g	ive street and number)	)		- 1	lb. City, Town, o	r Location of Deat	ber 03,	1999   of Death	1:17 P.M
1111101	Johns Hopkins H	ospital				Balti	more		N/A	
al	5. Social Security Number 6. 215–53–2115 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. la 1	st birthday) If Und Yrs. Month	der 1 Year Is Days	If Under 24 Hr Hours Mir	n. (Month, De	th ly, Year) 5, 1998	9. Birthplac Country Ma 1	ce (Steta or Foreign ryland
	10a. State 10b. County		10c. City,	Town or Location				4	100	1. Inside City Limits
tor	Maryland Bal	timore		Reister	stown					1 ☐ Yes 2 € No
Director	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of \	Whet Country	/?
=	110 Shropshire	Court			2	1136		U.	S.A.	
by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:			pecify Cuba 2KI No		Specify Yes or No orto Rican, etc.)	14. Rad Bled Specify	e American ck, White, etc Bla	C.
Completed	15. Decedent's I	Education rade completed)		16a. Decedent's Us (Give kind of	sual Occup	ation during most of w	orking	16b. Kind of B	usinass/Indu	stry
mpl	Elementary/Secondary (0-12)	College (1-4or	5+)						37 / 4	
	17. Father's Name (First, Middle, Las	0		Ne	ver E	mployed	ama (First, Middle		N/A	
B	Nathaniel L. I						imieka N			
10	19a. Informant's Name/Relationship			19b. Mailing Addre	es (Stroat					indel
	Ms. Shimieka N.		ther	110 Shro				rstown,		1136
	20a. Method of Disposition	Jenkins no	20b. Pla	ce of Disposition //	lame of		Date	20c. Location -		
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			rgreen Me		•	11/8	Finksbu	ro. MI	)
	21. Signature of Funeral Service Lice		HVC.				ral Dire			,
	1ansa		122							
	23a. Pint Enter the disease, or considered, or heart failure. List only	nolications that caused	True death			-	Randa1			133
Examiner	resulting in death)	b		às e consequence o					1	
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
n/Medical	Cause (Desease or Injury that initiated events resulting in death) Last	d	Due to (or a	s a consequence of	Ŋ:					
lc a	Part II. Other significant conditions	contributing to death b	ut not result	ing in the underlying	cause oiv	en in Pert I.	23b. Did	tobacco use co	ntribute to ti	he cause of death?
by Physician/W										bly 4 Unknown
Completed								en eutopsy ormed?	evaile	e eutopsy findings eble prior to pletion of cause eath?
Son							100	Yas 2□No	18	Yes 2□ No
Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only	ona)		
10	1 No 2 No	Hospital:		R/Outpatient 3 1		4 ☐ Nursing	Home 5 <del>⊠ Resi</del>			
on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 2	8b. Tima of 12:04 Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occur	red SUBUE	CT INHALED
CO	2 Accident investigation 3 Suicide 6 Could not	11 00 1		11:56 AM	1	Yas 2 No		BURNED IN		
Certification:	4 Homicide determined	28e. Place of fnj building, et	ury - At hom c. <i>(Specify)</i>	Heme RE			BALTIMO	Street end Numb vn, Stete) 110 RE	Shror Maryla	oshire Ct.
edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examinatio				e, and dua to tha	cause(s) and me	enner es stat	ed.
Med	29b. Signature and title of certifier	and manner sta	BIOG.	9	9c. Licens	e number	- I	29d. Date signe	d (Month. De	ev. Year)
1		111								
/	30. Name and address of person who	completed cause of d	my	Pa) (Time Print)	0.0	.M.E.		Novembe	1 04,	1999
	AND TRACTOR OF BUILDINGS OF DRISON WING	CARRESPONDED CHUSEATI (1	PORTUI LITERTI Z	CHIEF PRINCIPLE						
	111	Kul			nn St	reet, B	altimore	Marvla	nd 212	201

when it would per a affect

(3)

						tment of F			F	leg. No. 9	9 3	16404
hysician /Medical	Decedent's Name	(First, Middle, Las	Yun W	. Ki	. m			1	2. Date of Dea Month Novembe	er 20 1	Year 999	3:00 P.
Examiner	4a Facility Name (# 8053 Gr	100	street and number) Terrace Ap	t. 23	3		31	wn, or Loca Burn:	ition of Death	4c. County of		de1
ineral rector	5. Social Security Nu None	11	7. Age	(In yrs. la 82		If Under 1 Year Months Deys	If Under Hours	Min.	Date of Birth (Month, Day	(, Year)		ace (Stete or Fore ry) h Korea
M 18	Usual Residence of I	Decedent 10b. County		10c. City,	, Town or Loca	ition					10	d. Inside City Lim
10 of	Maryland	Anne Aru	undel	Gle	en Burn	ie						1 ☐ Yes 2🗓
miner must be notified at	10e. Street and Num 8053 Gre	ber enleaf T	errace Ap	ot. 2	3	10f. Zip Code 2106	51		1	10g. Citizen of W South		•
D.	11. Marital Status 1 □ Never Marrie 3 ☑ Widowed 4		12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		H.A	is Decedent of Horse, specify Cubic	an, Mexican	n, Puerto Ri	ity Yes or No- can, etc.)		- America c, White, e	
Completed	(Specif			+)	(Give kii life. DC	nt's Usuel Occup nd of work done NOT use retired	during mos	t of working		16b. Kind of Bus		ustry
	UNKNOW 17. Fether's Name (F				HOIR	emaker	18 Mothe	er's Name /	First Middle	Own I Maiden Sumame		
To Be	, and the second		Sung Yi Ki	m			10. 30.		n Dong		-/	
F	19a. Informant's Nar				19b. Meiling	Address (Street	and Numbe				State, Zip	Code) 2106
	Yong Cha	ae			8053	Greenle	af Tei	rrace	Apt. 2	23 Glen	Burn:	ie, Md.
	20a. Method of Dispo		Down olfow State	20b. Ple	ece of Disposit	ion (Name of tory or other ple	ce)		Date	20c. Location - 0	City or Tov	wn, State
		Other (Specify	Removal from State )	Но	ly Cros	s Cemet	ery	11,	/26/99	Baltimo	re,	Maryland
21 Singalumed Fungral Services Linearus 22 Name and Address of Equility										Funeral Home P.A. ltimore, Md. 21225		
lclan/Medical Examiner	Immediate Cause (F disease or condition resulting in death)  Sequentially list condification in any, leading to immediate. Enter Under Cause (Disease or in that initiated events resulting in death) La	ditions, nediate ying njury	c	Oue to (or	es e conseque es a conseque as e conseque	ence of):	Ca	ncu	~			
Cla	Part II. Other signific	ant conditions co	ntributing to death bu	t not resul	lting in the und	ertvina cause oiv	ven in Pert I	i.	23b. Did to	obacco use con	tribute to	the cause of dea
by Physician/M												ebly 4□Unkn
Completed t								_	24a. Was a perfor		con	re autopsy finding ilable prior to apletion of cause leath?
Co									1 🗆 Y	es 2 No	1 🗆	Yes 2□ No
B	25. Was case referre examiner?		Hospital:			Ott	205		Check only or			
ntion: To Be Com	1 Yes 2 N 27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	1 ☐ Inpatier  28a. Date of Injury (Month, Day)	, :	28b. Time of Injury	28c. Injur	4 LINU	28		ence 6 DOthe		)
Certification:	3 ☐ Suicide 4 ☐ Hornicide	6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At hor . (Specify)	ne, ferm, stree	t, fectory, office		28	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
edical			sician: To the best of iner: On the basis of and manner stal	examination								
	000 01	tle of certifier	1.			29c. Licens	se number		2	29d. Date signed	(Month, L	Day, Year)
×	290. Signature and tr	1 -				1 (0						
	290. Signature and to	In	HI-			D	256	54		11/221	199	
	▶ C	4 1 .	ompleted cause of de	ath (Item	23a) (Type, Pr	int)  N G	256 B 1	nn	Z	1061	198	



**DHMH 16 Rev 6/95** 

State Registrar

death with the Maryland

21215-0020

altimore, Maryland

P.O. Box 68760.

Division of Vital Records.

or Attending Physician:

KOPPISCH

CHARCIES

AME

BALTIMORE MIJ 21229

ms.

32 Registrar's Signatura

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

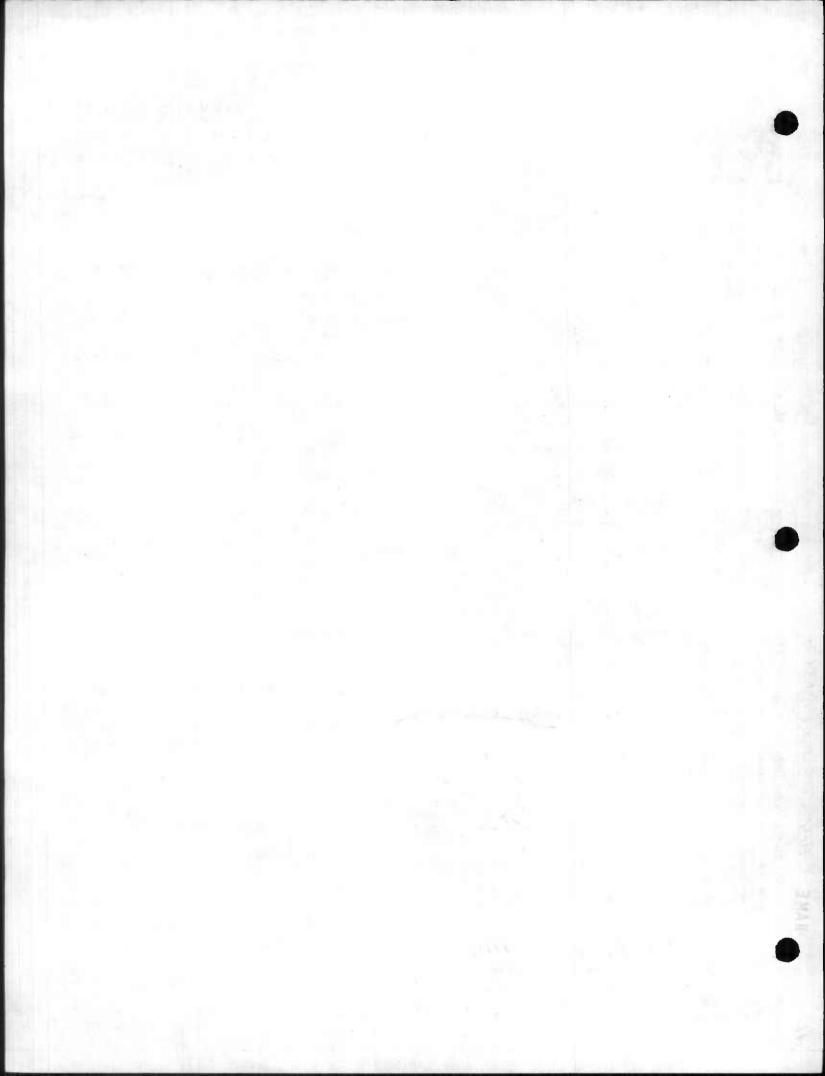
HOSY ITAL

Bonne

AGNES

35 95

GEORGE BAFFOE-BONNE



AMEND ITEMS: #23 PARTI, 27, 28A-F PEr PEr Mire at 6 Death - 18-99 WR. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** David William Krystkiewicz 4b. City, Town, or Location of Death /Medical 04:32 AM 13, 1999 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner 4221 Kenwood Avenue Baltimore Baltimore Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/26/1970 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 29 Months 220-06-6649 Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow MD Baltimore Baltimore 1 Yes 2 No Director 288-1 the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 4221 Kenwood Avenue 21206 "natural", or items 23s U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Depertment of Health and Mentel Hygiene. Important: If New 27 Is marked other than "natural" any Injury or other treumetic excessions. Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2₺ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpet Installer Carpet Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Karol Krystkiewicz Mary Regina Nolker 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Krystkiewicz 4221 Kenwood Avenue Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 1 Burial 200 remetion 3 Removel from State Balto/Wash. Crematory 10/18/99 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 21. Signature of Filheral Service License 6415 Belair Road Baltimore, Maryland 21206 23a. Pert1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List drily one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediata Cause (Final ETHYLENE GLYCOL INTOXICATION disease or condition resulting in death) Examiner Dua to (or es e consequence of) Examiner physician and the burlal-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Dua to (or as a consequence of): 980 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 1 Nes 2 No Division of Vital or Attanding Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 26a. Date of Injury (Month, Day Year) 10-13-99 4 hours efter death.

\*uneral Director: After the ely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Netural UNKNOWN 1 Yes 2 No SUBJECT DRANK ANTI-FREEZE 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number of Rural Route Number City or Town, State) 4 Z Z 1 K E NWOOD 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Directomplately filled in by HOME BALTIMORE, MARYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) my opinion. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME October 13, 1999 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Balto MD tenn St. hute, UD Dennis 31. Date filed (Month, Day, Year) 32. Registrar's Signature **NOV 1 8 1999** Registrar

mach of much construct

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#9 PER A.B. G777 11-22-99 J.A. Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 7:55AH inclum KMIG 10 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore

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Country

Country

NORTH Ravenwood Nursing Home 9. Birthplace (State or Foreign Country),
NORTH Black CAROL I 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1♥M 2□F 238-40-6224 76 Yrs. Director Usual Residence of Decedent the Meryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23e or 28a-f ehow The Medical Examiner must be notified at 1 □ Yes 2 □ No Director MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1120 E. Baltimore Street 21201 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: by Black. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mental Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James McKnight Minnie Autry 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) parmit. Peges 1 and 2 sh Depertment of Health end Important; If Item 27 Is in any injury or other treun once. Dwight Warren/friend 1120 E. Baltimore Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burlat 2 Cremation 3 Removal from State 4 ☐ Donation 5 NOther (Specify) in state lions that cause 21. Signature of Fune til Service Licensee Ronald S, 22. Name and Address of Facility Anatomy Board, 655 W. Baltimore Street, Ful Baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Betwe Onset and Death **Physician** metastatie gastrie Cancer Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician end the buriel-transit certificate be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) esn 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of After 1. Natural 5 Pending or Attendination after death. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completaly filled 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number

A-AHMED 31. Dete filed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
A-AHMED 821 N'Eulaw STRUE

NOV 2 2

32. Registrar's Signature

Ballimore MD 21201

Registrar

NOVER 18 18 1 Person

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 36408 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Hattie Elizabeth Lee November 16, 1999 10:00 A.M 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Rosedue
| Hunder 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 07-18-20 Baltimore FRANKlin Square Center HOSPITAL CE 5. Social Security Number Birthplace (Stata or Foraign Country) 6. Sex 10 M 20 F Months Days Hours 79 214-18-5987 **Usual Residence of Decedent** 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Mas 2□ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3818 Rexmere Road 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - Amarican Indian Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes ¥ No Specify Specify: 3€ Widowed 4 Divorced Black Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-for 5+) Motor Vehicle Admin 12th Grade NA Clerk 17. Father's Name (First Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Edward Thomas Sadie Henry 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 21218 19a. Informant's Name/Relationship (Type, Print) Player 3818 Rexmere Road Baltimore, Maryland Brenda 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Voshell Mem. Gardens 11-22-99 4 Donation 5 Dother (Specify) Dundalk, MD 22. Nama and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses WM.C.March FH 1101 E. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Cause (Final . Sepsis 10 DAYS disease or condition Due to (or as a consequence of): Methicillin Resistant Staphylococcus Aureus, Bacteriemio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. PNEUMONIA, CENTRAL line Sepsis . End Stage Chronic Obstructive Pulmonary Disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Malnutrition, Coronary Artery Disease 24b. Wara autopsy tindings available prior to completion of cause of daath? 24a. Was an autopsy performed? Ischemic Cardiomyopathy 1 Yas 2 No 1 TYas 2 No. 25. Was case refarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 N Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3∏ Suicide

physicien and the burlai-transit Box 68760. P.O. Records. The law requires Division of Vital this After

Examiner by Physician/Medical Completed 8 To Certification:

Physician

/Medical

Examiner

Funeral

Director

a notified at

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Name 23a

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**Physician** /Medical

Examiner

Pages 1 and 2 should be

Director

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Be

MD

Attending Physicien: n 24 hours efter deeth. e Funeral Director: Afti bletaly filled in by the fur ò To the Hosp within 24 hor To the Fune completely fi

Registrar

4 Homicide

(Check only anel

29b. Signature and title of certified

29a. Certifier

MD

112 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) November 16, 1999

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

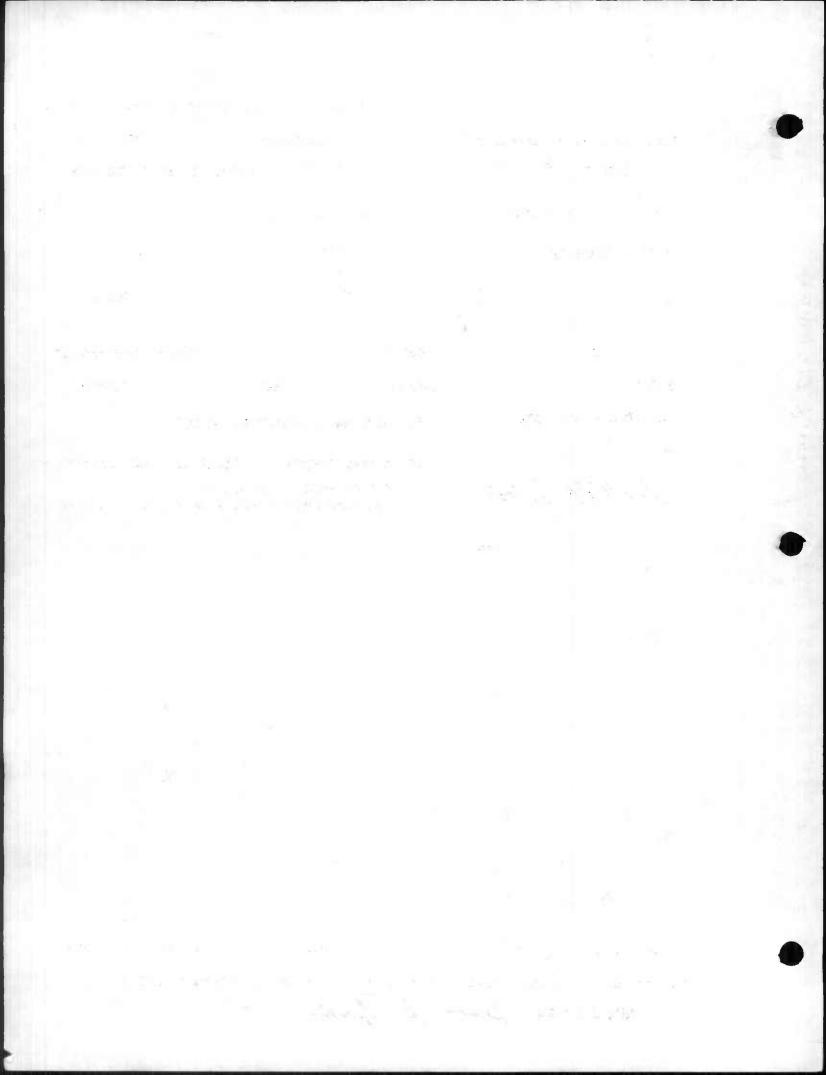
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 9000 Franklin Square Drive, Baltimore MD. 21237 Malika Waseem. 31. Data filed (Month, Days-Year) 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

Physician					Certificat	e or	Dealli		Reg. No.	2 0	0702	
	_	Decedent's Name (First, Middle, La:     HARRY	st)		TTO	DM B 53		2. Date of D	Day	o d'ear	3. Time of Death	
/Medical	4	TARK!  1e. Fecility Name (If not institution, give	a street and number)		LIE	BMAN		November Location of Dea			4:55 p.r	
Examiner	-	Sinai Hospital of					Baltimo		on of Death 4c. County of Death N/A			
uneral irector	5	5. Social Security Number 6. S							irth 21, 191:		ce (State or Fore	
how	1	Usuel Residence of Decedent  10a. State 10b. County  MD BALT	IMORE	10c. City, Town o		TIMO	20		•		d. Inside City Lim	
r 28a-f show incitied at irector	L		INORE			TIMO	KE				1 ☐ Yes 2 ☐X	
in or man be not ted		6 FARRINGDON CT	•		10f. Zip		209		10g. Citizen of	Whet Countri SA	y?	
by by	١.	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorcad	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban				(Specify Yes or N erto Rican, etc.)		ice - American ack, White, et ify: WHITE	c.	
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and Hygiene and Autoral Its Western Its We		17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middl			JICI II JO		
atic e		SOLLY		LIEBM	AN		REC	CHA		UNKI	NWO	
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ury or	1	Burial 2 Cremation 3 4 Donation 5 Other (Specify			crematory or o		· ·	11/1			STOWN, M	
any Inju	2	21. Signature of Funeral Service Licen	Citte		22. Name an	d Addre	ss of Facility NSON & I	BROS., I	NC.			
edical aminer	Immediate Cause (Final disease or condition resulting in deeth)  Due to (or es e consequence of):									Ö	ntervel Between Onset and Death	
attending physician and for use as the burial-transit clan/Medical Examiner	t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	c	ue to (or as a cor								
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o si		ant II. Other significent conditions or	d.	not resulting in th	e underlying c	ause giv	en in Part I.		tobacco use c		he cause of dea bly 4 ⊡ Unkno	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death Month Η. Lozoskie 18, 1999 2:15 AM November 4e Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death St Elizabeths Rehab & Nursing Center Baltimore Baltimore City If Under 24 Hrs. 8. Dafa of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yaar | Months | Days 5. Social Sacurity Number Birthplace (Stata or Foreign Country) 1□M 20F 90 218-28-5413 Usuel Residence of Decedant 10e Steta 10b. County 10c. City. Town or Location 10d. Insida City Limits Baltimore 1 ☐ Yas 2 No Dundalk 10e Streef and Number 10f. Zip Code 10g. Citizan of What Country? 7825 Kentley Rd 21222 USA 12. Was Decedanf Evar in U,S. Armed Forcas? 1 ☐ Yes 23 No If Yas, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian. 11. Meritel Stefus Black, White, atc. 1 Nevar Merried 2 Married 1 ☐ Yas 2K No Specify: 3 Widowed 4 ☐ Divorced White 15. Dacedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collega (1-4or 5+) 8 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Benedict Martha Bastas 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Mastroianni /daughter 7825 Kentley Rd Baltimore, MD 21222 20b. Place of Disposition (Nama of camatary, crematory or other place) Nov 22 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ⊠ Burial 2 □ Cremetion 3 □ Ramovel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, MD Sacred Heart of Jesus 1999 21. Signatura of Pubaral Service Licensee 22. Nama and Addrass of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd time 23a. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart faiture. Ust only one cause on each line. Approximata Intervel Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in daath) Atheroschelotic Caedio vasculae Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting in daeth) Lest Dua to (or as a consequence of): Dua to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Wara autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 No 25. Was casa raferrad to medical axaminar? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28a. Placa of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

Examiner physician and s the burial-transit The lew requires that the death certificate be asscuted Box 68760, Physician/Medical 88 P.O. I Division of Vital Records. ð Completed or Attending Physician: Be this funeral After

Certification: To after death. filled in • Funerei Hospitai

**Physician** 

/Medical

Examiner

MD

Director

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or her eny injury or other traumatic event, the Madical Examina

**Physician** 

Examiner

/Medical

Baitimore, Maryland 21215-0020

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**DHMH 16 Rev 6/95** 

State Registrar

Medicai

31. Defa filed (Month, Day, Year)

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(Check only one)

29b. Signature end MIII of certifie

Jyotin

29a. Certifier

Tarikh Mb 32. Registrar s Signatura

30. Nema and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

821 N. Enfan St, Suite 407, Baltimore, 141 21201

to certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

Wedical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

32158

29d. Date signed (Month, Day, Year)

11/18/99

**ORIGINAL** 

Nov 2 308 Jan 1998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item. 1, 3, 4a, loe, 16a, 17, 18 per informant G780 2/9/00 yg per fh, Phys. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 3 Time of Death 2. Dete of Death Month Year Physician Franklin David Longfellow Franklin Longfellow November 13, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Center Gilcrist Center 7. Age (In yrs. last birthday) | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 83 | Yrs. | Months | Days | Hours | Min. | March 6, 1916 Towson Baltimore Hospice of Baltimore Gilchrist 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 552-05-4447 110 M 2□ F Director Canada Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow Baltimore Towson 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Apt 317 307 7925 York Rd 21204 USA Funeral 14. Raca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) should be filed within 72 hours after and Mental Hygiena. 1X Yes 2 No If Yas, Give 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use relired) Management Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Maintenance Supervisor Oil Industry 18. Mother's Neme (First, Middle, Malden Sumame) 17. Fathar's Neme (First, Middla, Last) Be 1 and 2 should be Health and Mental Elwood Trwin Longfellow Nettie Dale Netta Weir Dale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a H Item 27 is or other tre Susan Randall/daughter 14242 Cuba Road Cockeysville, MD 21030
Dete 20c Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of h 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from State permit. Page Department in state 4 ☑ Donation 6 ☐ Other (Specify) 21. Signature of Funeret Service Licensee Ronal d 22. Name end Address of Fecility Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Daath Physician mocer of uncertain /Medical Immediata Causa (Final 6 month diseese or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of) Pert It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Yong kellow, 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No cartificate Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpatienf 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS MICE 1 Yas 2 No Medical Certification: To of this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division Attending 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. invastigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ò Hospital to Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted. 29a. Certifier completaly (Check only one) To the Vithin 2 29b. Signatura and fittle of certified 29c. License number 29d. Date signed (Month, Day, Year) uns 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Balto, M6 21204 620 N. Charles er 31. Dete filed (Month, Day, 32. Registrar's Signeture State Registrar

#H

NO. 5.5 1888 Server 12 House

A	MEND#516a,t	, &20a-20c P	ER F.H. G778	12-14-99	Certificate of	Death		Reg. No.	J	3. Time of Death
Physician	1. Decedent's N	ame (First, Middle, Las	St)				2. Date of De Month	Day	Year	
/Medical		eth Lester					Novemb			16:38 pm
Examiner	4a Facility Name	e (If not institution, give	a street and number)			4b. City, Town, or Lo	ocation of Deatl	4c. County o	f Death	
		erndon Cou				Baltimo	re		N/A	
Funeral Director	5. Social Securit		ex 7. Aga	(In yrs. last birth	Months Dave		8. Data of Bir (Month, Da Jan 25	th ly, Year) . 1938	9. Birthpl Count	lace (State or Foreign try) MD
	Usual Residence	of Decedent						, 1,50		
Les neutified at	10a. State	10b. County		10c. City, Town	or Location				10	Od. Inside City Limits
r tiems 23a or 28a-f si niner must be notified Funeral Director	MD			Balti	more					1□ Yes 2□ No
r 28	10e. Street and	Number			10f. Zip Code			10g. Citizen of Wi	hat Coun	try?
San San San San San San San San San San	830 H	erndon Cour	rt		21225				USA	
Jer Line	11. Marital Statu	s	12. Was Decedent E	ver in U,S.	13. Was Decedant of	Hispanic Origin? (Sp	ecify Yes or No	- 14. Race	- Amarica	
by		erried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: U		1 ☐ Yes 2 💢 No	Specify:	rican, etc.)	Specify:	, White, o	nite
	10	15. Decedent's Ed	ucetion	16a. [	Decedent's Usual Occu	pation	do a	16b. Kind of Bus	iness/Ind	lustry
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To	un	known				unk	nown			
E .	19a. Informant's	Name/Relationship (7	Type, Print)	19b.	Malling Address (Stree			er, City or Town, S	State, Zip	Code)
other trau	Miss L	ucas/frien	d		unknown				第	
or other traumatic event, the Medical To Be Completed	20a. Mathod of I		- 2.5		Disposition (Name of , crematory or other pla	ace)	Date	20c. Location - C	ity or To	wn, State
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any injury or		Funeral Service Licen Ronald		Director		ess of Facility natomy Bo			•	e Street
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100	shock, or h	eart failure. List only	one ceuse on each line	the death. Do no e.	ot enter the mode of dy	ing, such as cardiac	or raspiratory a	rrest,		Approximate Intervel Between Onset and Death
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Sic	Part II. Other sig	nificant conditions co	ontributing to death but	t not resulting in	the underlying cause g	iven in Part I.	23b. Did	tobacco use con	tribute to	the cause of death?
be detached for use at by Physician/M							10	Yes 2□ No	3 Prot	bably 4 Donknown
should b							24a. Was	an autopsy	24b. We	ere autopsy findings allable prior to
Completed							pene	ormed?	COI	mpletion of cause death?
dmo							10	Yes 2 No		Yes 2 No
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edical Cert	29a. Certifier (Check only one)	2 Medical Exam	ysician: To the best of liner: On the basis of and mannar stat	examination and	death occurred at the t /or investigation, in my	ime, date and place, opinion, deeth occur	and due to the red et the time,	cause(s) and mar date and place, a	nner as si nd due to	tated. tha cause(s)
1	295. Signature a	ind title of certifier	36		29c. Licen	isa number		29d. Date signed	(Month,	Day, Year)
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		ddress of person who				: 41100	VED C	7		
	MARC	). /		no	1147 5	, HANDE	([1])			
State		fonth, Day, Year)	32. Registra	r's Signature						
Registrar	NOV 2	2 1000	.6.	1						

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State of Maryland / Department of Health and Mental Hygiene

36413 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** Mayhorne Kau November 18 1999 12:28 am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF Months 217-40-1339 55 Director Aug. 17,1944 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits the Marylar ahow 1 Yes 2 No Director 28a-f Dundalk Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? "natural", or flame 23a or 9 German Hill Road 21222 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, Whita, atc. filed within 72 hours after Hygiene. Ther then "natural", or the 1 Yas 2 No If Yas, Giva Yeer or Detas: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important! If them 27 is marrised other tha any Injury or other trassments 11 Years Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surnema) 8 Francis E. Hewitt Louise W. Webster 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mr. Davis Mayhorne (Husband) 9 German Hill Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 Donation 5 Other (Specify)

21. Signature of Juneral Service Licensee Craigsville Cemetery 11/20/1999 Augusta, VA 22. Name end Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, provided the deeth. Approximeta Intarval Batween Onset end Death Physician Immediata Causa (Final diseasa or condition resulting in death) . Small Cell Carcinoma of the lung /Medical 1 month Examiner Examiner attending physician and for use as the buriel-transit To the Mospital or Attanding Physician: The lew requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funest director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence ot): P.O. Box 68760, Physician/Medicai Dua to (or es e consequance ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown LIVER CIRRHOSIS Records, p 24b. Ware autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 8 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Medical Certification: To 1 Yas 2 No 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be Ptace of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and mannar es steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) end mannar stated. 29b. Signature and title of certified 29c. License number 29d. Data signad (Month, Day, Year) m. Commer, mo November 18, 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) SUZanne M. Calcamese, MD 4940 Eastern Avenue Baltimore, Maryland 21224 31. Data filed (Month, Day, Year) 32. Registrar's Signature State NOV 22

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day **Physician** Albert Matelis Benedict November 17 1999 2:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3607 Lilac Ave. Baltimore Baltimore | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer) | Oct. | 6,1921 5. Social Security Number If Under 1 Year Birthplace (State or Foreign
Country) 7. Age (In yrs. lest birthday) **Funeral** XXM 2DF Months Days 215 12 9166 78 Yrs Maryland Director Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f show the Maryla 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or learns 23e or the Medical Examiner must be 3607 Lilac Ave. 21227 United States 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. filed within 72 hours after thyglene. ther then "natural", or lies 1 XYes 2 No.
If Yes, Give WWII
Year or Dates: 1 Never Merried ★ Merried Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Goddard Space Flight Elementary/Secondary (0-12) College (1-4or 5+) 4 Technical Engineer 12 Center permit. Pages 1 and 2 aboud be fila Department of Health and Menial Hy Important if Item 27 is merked oths any injury or other traumeds event, pinds. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Frank Matelis 7.imitas Marie 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Albert J. Matelis / Son 3607 Lilac Avenue, Baltimore MD 21227 Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) St. Stanislaus Cemetery 11/19/99 Baltimore MD 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. Jasley Xoduna 8717 Green Pastures Dr., Balimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Metastatic Prostate Cancer yrs. Examiner Due to (or as e consequence of) Examine ettending physicien and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initial to a second conditions of the condi Due to (or es a consequence of): Box 68760. edical the desth certificate be that initiated events resulting in death) Last Due to (or es e consequence of) Physician/M Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect 1 Yes 2 No 3 Probably Cunknown ģ 24a. Wes en autopsy performed? 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? Completed been a P.88 1 Yes 2 No 1 Yes 2 No Division of Vitai 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home Residence 6 Other (Specify) 1□ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) To the Hoepital or Attending PI within 24 hours effer deeth.
To the Funeral Director: After the completely filled in by the funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 1 Natural 5 Pending investigation a effer deeth.

I Director: Affed in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 17, 1999 D36942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 B. Turaichia, MD 1009 Frederick Rd., Baltimore, MD 31. Date filed (Month, Day, Year) NOV 2 2 32. Registrers Signeture State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #18 AMENDED ITEM #5 PER FH G77812/15/99 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** NOVEMBER 22, 1999 HERSCHEL J. MASSEY. SR. 7:10 A.M /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Boitimere CATON MANOR NURSING HOME If Under 24 Hrs. If Under 1 Yeer Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** XXM 2DF Months Days Hours Yrs 94 GEORGÍA Director 3/24/1905 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at BALTIMORE CITY XXYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 218 S. VINCENT STREET 21223 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2200 No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours efter 1 Never Merried XX Married Specify.WHITE Saltimore, Marviand 21215-0020 1 Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED GROCER Peges 1 and 2 should be filed value to Heelth end Mentel Hygie int: If them 27 is marked other t 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) Be FLORRIE KEEBLER JOHN MASSEY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth el Important: If Hem 27 is eny Injury or other tree PAULINE H. MASSEY 3300 BENSON AVENUE, APT 101 BALTIMORE, MD 21227 20a. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete emetery, cremetory or other place) 1 X Suriel 2 Cremetion 3 Removal from Stete 11.24.99 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) CEDAR HILL CEMETERY Funeral Service License 22. Name end Address of Fecility FINK FUNERAL HOME, PA Julgony 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061 23a. Pel 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of). Examiner reprovaccular accident ulhole that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last and Due to (or es e consequence of): physician Box 68760. Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Tes 2 1 No 1 Yes certificate tistory anoma Division of Vitai or Attending Physicien: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 √ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28h Time of 28c. Injury et Work? After 1 Neturel 5 Pending after deeth. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) within 24 hours after def To the Funeral Director completely filled in by th 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signeture end fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar raline

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrer's Signeture

DHMH 16 Rev 6/95

November 22.1999

1838 Greene Tree Road Suik 300,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Month A Physician DOROTHY MASIMER 11:25 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND HOSPITAL H Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
APRIL 5, 1923 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign Funeral Days 1 M 2 TF Months Director 76 MARYLAND 217-20-3096 Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yas 2 ☐ No Director MARYLAND ANNE ARUNDEL PASADENA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1125 HOLMESPUN DRIVE 21122 death II.S.A 14. Race - Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 ☐ No Specify Specify à 3 ☐ Widowed 4 ♥ Divorced "neturel" WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry se filed within 7 ial Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3 HOME MAKER OWN HOME permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy, Important: if Item 27 is marked othe any Injury or other traumatic avant, page. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) KING HARRY CONSTANCE GRENOVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) PATRICIA D. PALEN- DAUGHTER 961 BENNETT ROAD, ARNOLD, MARYLAND 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 11/24/99GLEN BURNIE, MD 22. Nama and Address of Facility SINGLETON FUNERAL HOME, PA. SECOND AVE., S.W., GLEN BURNIE, MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, that the death certificate be Physician/Medical Due to (or as a consequence of) 980 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed I Records, à 24b. Were autopsy lindings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 a 1 □ Yas 2 No 1 □ Yas 2 □ No this certificata Division of Vital 25. Was casa refarred to medical axaminer? or Attending Physician: director. Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 20 No Certification: To 1 12 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 Yes 2 No Director: A 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d 4 Homicide within 24 hours after To the Funeral Director completaly filled in b 29a, Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated. Medical To the To the To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier PRESIDENT PHYSICIAN

State Registrar

DHMH 16 Rev 6/95

22 South Curoca

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

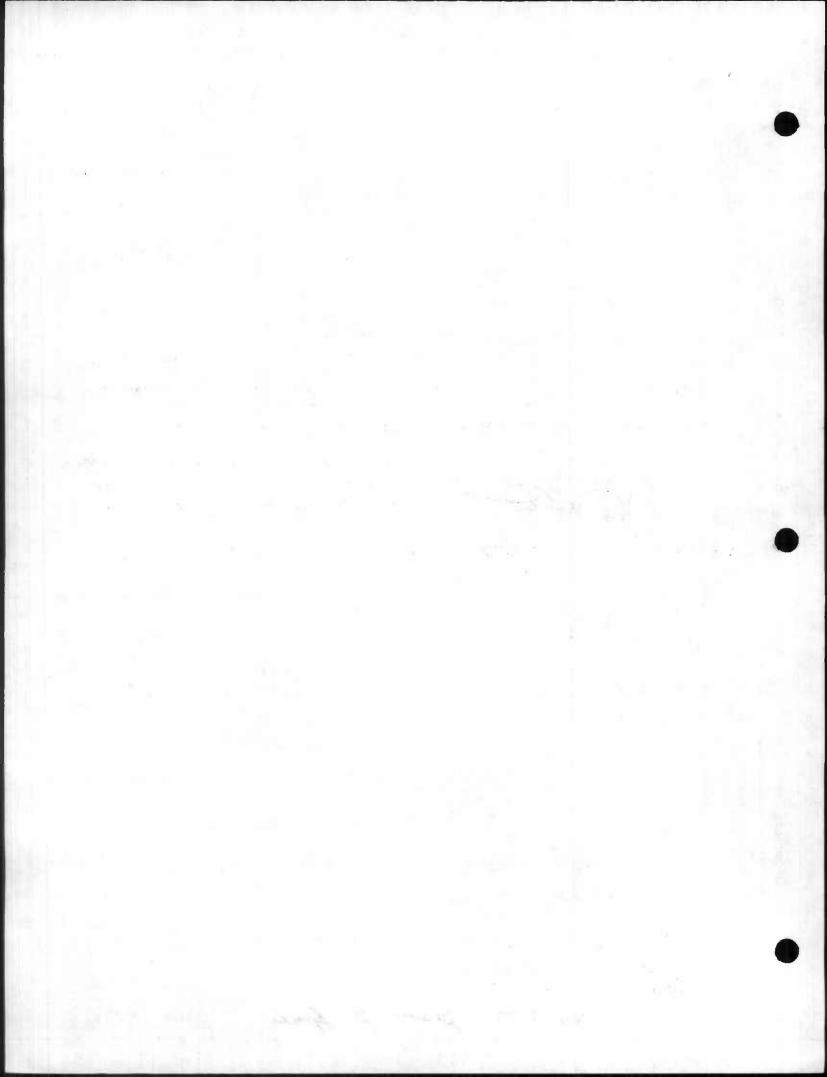
32. Registrar's Signatura

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Chudnorsy, m.D.

NOV 22

31. Data filed (Month, Day, Year)



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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev ESSIE Month MILLER 2. Isam NOVEMBER 21 1999 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth SAMARATAN BALTO. HOSPITAL 500D If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 M 2 1 216-20-615 May 13, 1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 U.S.A RALWORTH 1653 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 Ho Specify: Specify white 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) + company 12+1 W. Grace ANALYST NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) DIFFER Brugh HARRINGTON JOHN NeL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21218 charles RALWORTH BALTO MD Miller (husband 1453 RD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Defermetion 3 Removal from State BALTO. ND. 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cenetery 11/23/39 HARTLEY Miller FUNER HOME CHTD Funeral Service Licensee 22. Name and Address of Facility 7527 HArFord BAND. MD 21234 RD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or es a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Pages 1 and 2 should be filled within 72 hours after death vant of Health and Mental Hyglens.
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Baitimore, Maryland

Records. P.O. Box 68760.

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Division

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. noscleratic disease 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? NTH 1 | Yes 2 | No 1 Yes 2 No 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) NOV 22

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Lock Roven

Blva 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltwie

P11391

November 21, 1999

MICHEL

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day -REDERICK 6:51 PM NOVEMBER 18, 1999 MILLER JR. 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth FALLSTON General HOSPITAL HARFORD FALLSTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 10M 20 F 216-28-0700 6 Yrs. SEPT an Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No HARFORD FALLSTON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2301 EDINBURG DRIVE 21047 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: KOREAN Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GAS COMPANY 12+4 SUPERVISOR NIA 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) FREDERICK D. Miller ED ITH . SR HALL 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LERGY N. WILLES (wife 2301 EDINBURG . DR. FALISTON MD 21047 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Daurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. PAUL'S LUTHORAN CEM. 11/22/99 KINGSVIlle, MD 22. Name end Address of Facility 21. Signature of Funerel Service Licensee HARTLEY Miller F HARTLEY Miller F Funeral Home CHTD. BALTO 7527 MD Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, ock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final METASTATIC CANCER disease or condition resulting in death) Due to (or es e consequence of): PROSTATE CANCER Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Tyes 250 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending

The law requires that the death certificate be executed -trensil and Box 68760, ed by the ettending physician detached for use es the burie P.O. ate hes been signed by pege 2 should be detac Division of Vital Records, certificate hes To the Hospital or Attanding Physician: within 24 hours effer deeth.

To the Funaral Director: After this certifica completely filled in by the funerel director; p

Examiner Physiclan/Medical þ Completed Be 2 Certification:

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i. Pages 1 end 2 should be fill timent of Health end Mental H tant: if frem 27 is marked out jury or other traumatic ever

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3 Suicide 4 Homicide 29a. Certifier

2 Accident

investigation 6 Could not be determined

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29b. Signature end title of certifier DML

29c. License number OCME

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

29d. Date signed (Month, Dey, Year) NOV 18 1999

30, Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Fulford AVE NABEN. 218

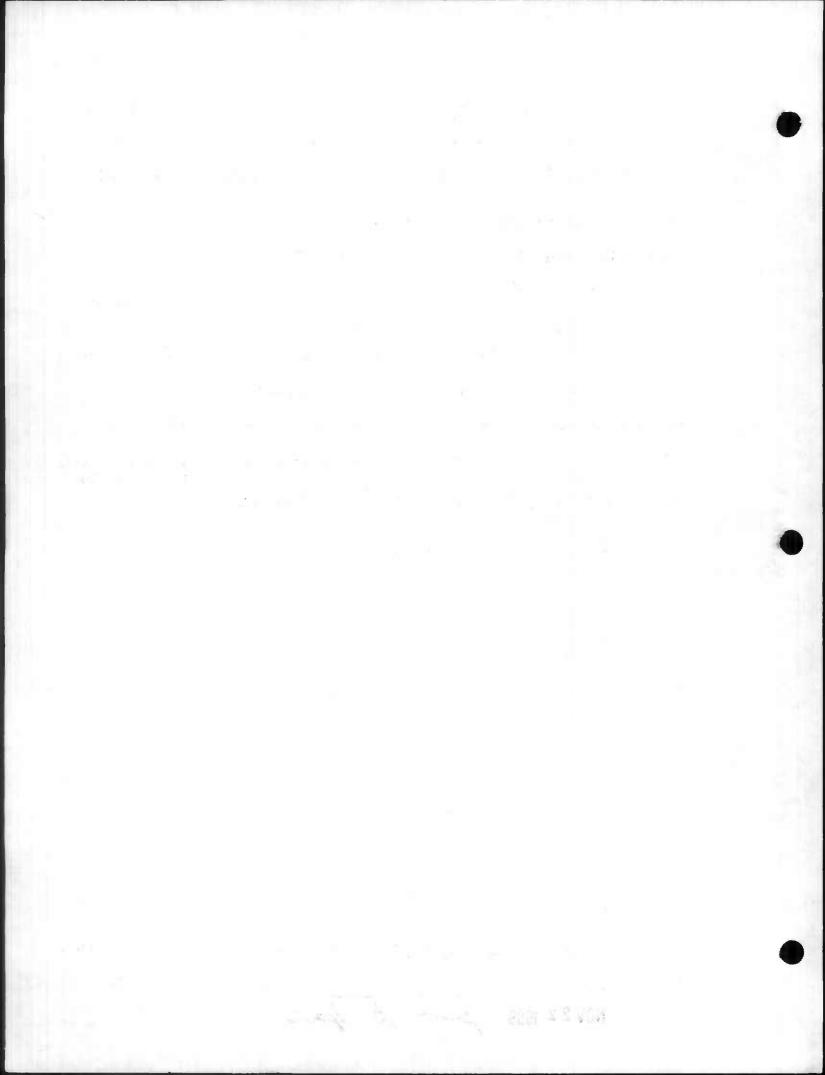
31. Dete filed (Month, Day, Year)

NOV 22

32. Registrar's Signeture

BELAIL MD 21014

State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da **Physician** Irene Namuth November 19, 1999 2:00 AM Orr /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8059 Woodholm Circle Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 V Yrs. 82 10, Director 449-20-8000 Feb. Texás Usual Residence of Decede the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nant of Health and Mental Hyglans.
Int: If item 27 is marked other than "natural", or frems 23s or 28s-f show Iry or other traumatic avent, the Medical Examinar must be notified at Pasadena Md. Anne Arundel 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 8059 Woodholm Circle USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical US Government Finance Dept.Ft. Meade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudd Hollinsworth Tom Cora 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Shirley Brabbin (Aunt)</u> 2525 Robin Lane, Garlin Texas 75041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or page. Metro Crematory Inc. 11/20 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Diserv 22. Name and Address of Facility Stallings Funeral Home PA ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. 23a. Part1. Enter the disease, or complishock, or heart failure. List only o Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final luman Pai disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown bengis þ 24b. Were autopsy findings available prior to completion of cause of death? been signature 24a. Was an autopsy performed? Completed page 2 1 Yes 2 ZNO 214 No certificata director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending To the Hospital or Attanding within 24 hours after death.
To the Funeral Diractor: Afte completely filled in by the fun 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred. edical 29a. Certifier iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. (Check only one) 29c. License number 29d. Date sign#d (Month, Day, Year) 29b. Signature and title of certifier Torbaty MD 30. Name, and address of th (Item 23a) (Type, Prid 7845

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year) NOV 2 2

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strar's Signature

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Dete of Death Month NOV. **Physician** Palmer 9:00pm Pearl /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Irvington Knolls Nursing Home If Under 1 Year Months | Days If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 212-20-0489 84 Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at XXYes 2 No Director Baltimore 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 22 S. Athol 21229 Avenue USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, epecify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after Yes RNNo f Yes, Give 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) permit. Pages 1 and 2 should be filled will Department of Health and Mental hygien. Important: if Item 27 is marked other transits with Injury or other traumatic curve. Domestic 7th Grade other people homes 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Dennis Waters Carrie Pope Waters 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19131 5340 Lansdowne Avenue Philadephia, PA Justine Waters 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Kings Mem. Pk. Cem. 11-24-99 Randallstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. Nroth Avenue 23a. Part1. Enter the disease, or complications that caused the dualfy shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final stem infanct 6 month disease or condition resulting in deeth) Examiner Examiner Chebro vasular attending physician and for use as the bunk-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physicien:
 A hours after death.
 Funerel Director: After this certifical etely filled in by the funeral director. Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 8 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) in 24 hour.
the Funeral Dire.
To filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier To the Vithin 2 To the Complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031865 mian-DKA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N autour street Balt md Rm 206 mion -000 Kioune 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

1999 - 1999 persone

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth NOU 58 PM RICHARD **JAMES** PHILLIPS 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TEN BURNIE If Under 24 Hrs. 8. Date of Bi 5. Social Security Number 7. Apa (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 100 M 20 F 270-26-3336 69 JUNE 20, OHIO Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes XX No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 JUNIPER DRIVE 21060 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 12 Yes 2 No 1952— If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Bleck, White, etc. 1 Never Married X2 Married 1 Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER WESTINGHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARTIN PHILLIPS MARTE ATKINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DOLORES PHILLIPS (WIFE) 200 JUNIPER DRIVE, GLEN BURNIE, MARYLAND 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 11/19/99 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION CENTER, LLC STEVENSVILLE, MD. yre of Fulgeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conduction if any, leading to immedicause. Enter Underlying Cause (Disease or injury Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 212 ER/Outpatient 3 DOA 27. Manner of De 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 ANatural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide

Physician/Medical Examiner physician and the burier-transit The lew requires that the death certificate be assocuted Box 68760, USB 88 P.O. Records, Completed of Vital 8 To this Certification: Division or Attending death. Director: A 2

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29a. Certifier

(Check only one)

29b. Signature and title

Physician

/Medical

Examiner

**Funeral** 

Director

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should be filed within 7 and Mental Hygiene.

Pages 1 and 2 should be hent of Health and Mental

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Physician

/Medical Examine

Maryland

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Completed

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> State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day,

32. Registrar's Signature

use of death (Item 23a) (Type, Print)

Aguahart Road, Suite 203, Glen Burnie, MD 21061

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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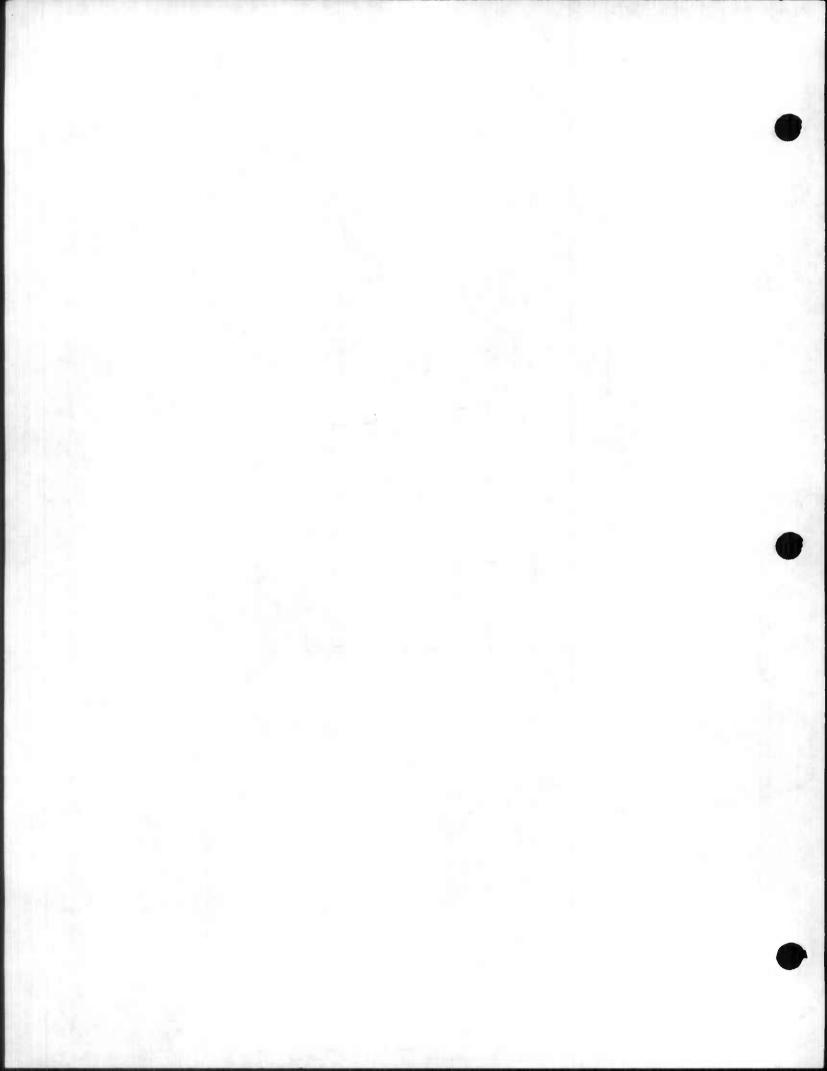
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36424 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** NOVEMBER 18 10:33AM /Medical liby Name (If not institution, give street and number) 4b, Vor Location of Death 4c. County of Deat Examine TOPICE SBAYVIEW DAYTMOKE II Under 24 Hrs. J 8. Dete o If Under 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 2 XF 69 023-22-9627 20,1929 Director Dec. Massachusetts **Usual Residence of Decedent** with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. toside City Limits r than "naturel", or hema 23a or 28a-f ahow the Medical Examiner must be notified at 1 TYes 200No Directo Maryland Baltimore Dundalk 10e. Street end Number 10f Zip Code 10g. Citizen of Whet Country? 7730 Fairgreen Road 21222 United States deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Bleck, White, etc. 11 Marital Status filed within 72 hours effer. Hygiene. Wher then "naturel", or file 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: aitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled wit Depertment of Heelth and Mental Hyglent Important: if item 27 is marked other that eny filury or other traumatic event, stra. PARS. 10 Years Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Alfred Rov Delia Renaud 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Nancy A. White (Daughter) 7227 Stratton Way Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other 20a. Method of Disposition Dete 20c. Location - City or Town, Stete tery, cremetory or other piece) 12 Burial 2 Cremetion 3 Removal from State Sacred Ht. of Jesus Cem. 11/22/99 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximele Interval Between Onset end Deeth **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner nakin physicien end the burlei-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): = attanding 887 ŏ signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy tindings eveileble prior to Completed 24a. Wes en eutopsy performed? Deen completion of cause of death? hes pege 2 VOS YOS 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpetient PER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 No Yes 2 No this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death he Hospital or Attending Ph in 24 hours after deeth. he Funeral Director: After th plataly filled in by the funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) within 2 ş Ş

State Registrar

29b. Signature and title of certifie

Valtkevicing P.

31. Date filed (Month, Day, Year)

Neme end address of person with

**DHMH 16 Rev 6/95** 

Completed cause of death (Item 23a) (Type, Print)

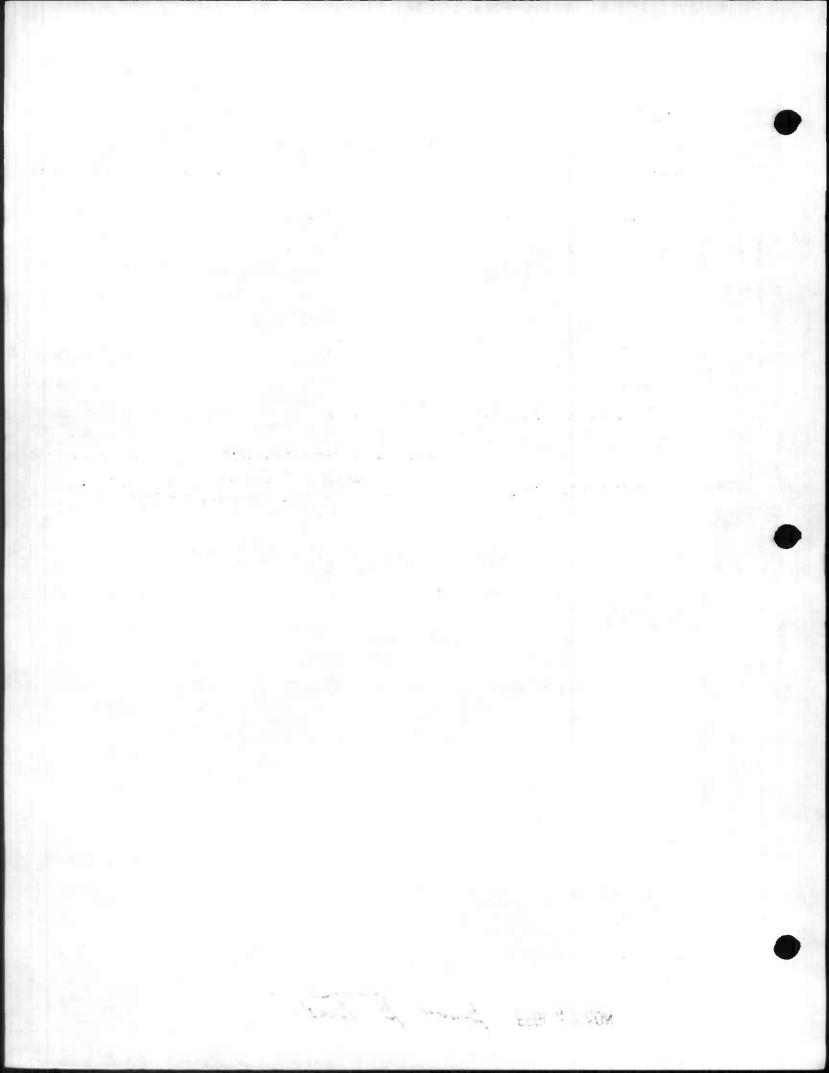
32. Registrar's Signetura

OMNS NO

29c. License number

36870

29d. Dale signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 08:35AM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Raymond Melvin Royston /Medical Nov 18 1999 4c. County of Death 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) Examiner Saint Joseph Medical Center **Baltimore** Towson
If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2□F Days Hours Yrs Director 219 01 8373 79 March 4,1920 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d Inside City Limits items 23s or 28s-f show Maryland Baltimore Cockeysville 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 13801 York Rd. Unit C18 21030 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 72 hours efter 1 XYes 2 No If Yes, Give WW II & Year or Deer ean Con. 1 ☐ Never Merried 2 🖫 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) Insurance Agency Self Employed 12 4 permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If item 27 Is marked ofter any Injury or other traumatic event page. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First Middle Last) Be Raymond Royston Schmidt Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Jeanette Royston / Wife 13801 York Rd., Unit C18, Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremetion 3 ☐ Removel from State Chesapeake Crematory Inc. 11/19/99 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. deplet tobererann 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Aspiration Pneumonia disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit certificate be asscuted Sequentielly tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or es a consequence of): 980 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1□ Yes 2□No 3 Probably 4 Unknown Records, ò 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peed completion of cause of death? has 1 Ves 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes ¾XNo Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending Patter death.

Director: After i After Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital c thin 24 hours at the Funeral D 29a. Certifier edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number natividad D. de feon, m.D. D 19508 November 18, 1999 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 7601 Osler Dr., Towson, MD Natividad D. DeLeon, MD,

**DHMH 16 Rev 6/95** 

Registrar

31. Dete filed (Month, Dey, Year)

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32. Registra s Signature

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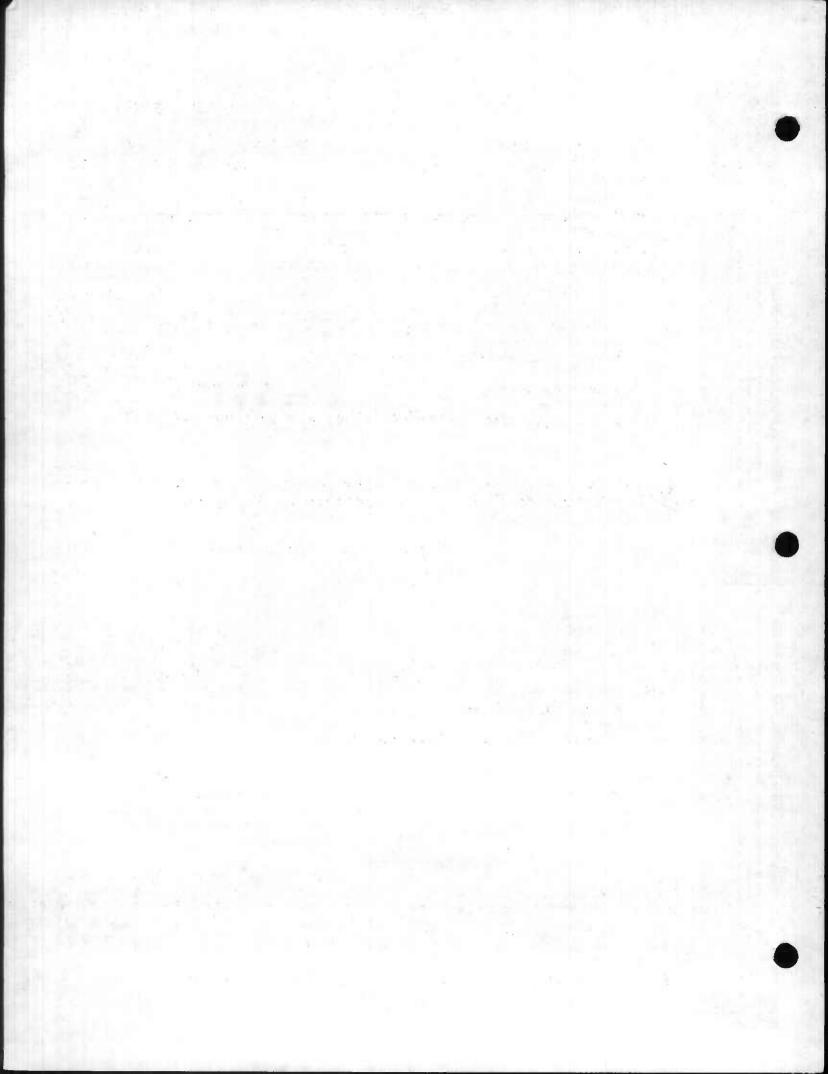
Certificate of Death

D43725

201-109 Back River Neck Rd Baltimore 21221

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician	Decedent's Name (First, Middle TENNITE			CHEAD		2. Deta of Dea	Dey	Year	Time of Deeth	
/Medical	JENNIE	E	1	SHEAR	4b. City, Town, or Lo	NOV	1		:05PM	
Examiner	4a Facility Name (If not institution HOLY CROSS HOST				SILVER S	PRING	MC	ONTGOME	RY	
Funeral Director	5. Social Security Number 236-36-2190  Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birtho 94 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth Mooth, Day MAY 31	, Year) 1905	9. Birthplace Country RUSSI	(State or Foreign	
Meryland 4 ahow	10a. State 10b. County	VIGOMERY	10c. City, Town o	r Location ROCKVILLE					nside City Limits Yas 2 □ No	
h with the Mer 3a or 28e-fal at be notified	10e. Street and Number 6111 MONTROSE	RD.		10f. Zip Code 208.	52		10g. Citizen of V USA	Vhet Country?		
5-0020 72 hours after death with the Menyland 72 hours after death with the Menyland field Examiner must be notified at sted by Funeral Director	11. Marital Status  1 Nevar Merriad 2 Mer  3 Widowed 4 Divorced		No	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blace Specify	e - Amarican In k, White, etc.	HITE	
	15. Deceder (Specify only highe Elementery/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) /Secondary (0-12) College (1-4or 5+)		ecedent's Usual Occup live kind of work done le. DO NOT use retired OWNER	ing 16b. Kind of B		Business/Industry			
Hygie ther the Co		Lasti		OWLVER	18. Mother's Name	ne (First, Middle, Maiden Surname)				
ire, Marylana Z.I.Z. s. 1 and 2 should be filed within the 27 is marked other than other traumatic avent, Tra.III To Be Compl	HARRY		FRA	M	DOR	•		PATS		
2 sho send le me	19e. Informent's Name/Reletions			lailing Address (Street				20001	e) .	
Health ther tr	MRS. RUTH LEV	LN (DAU.)		17 DOWNS Disposition (Name of		R SPRIN	20c. Location -	20904 City or Town, 5	State	
Page nent o mrt: If	1 Surial 2 Cremetion 4 Donetion 5 Other (S	(pecify)	MIKRO	isposition (Name of crematory or other plac KODESH-BE	IH ISRAEL			LTIMORE		
Departit. Departit mports any injects. Dece.	21. Signature of Funeral Service	u Lui		8900 REI	NSON & BROSTERSTOWN	RD. P	IKESVILI	E, MD	21208	
Physician	23a. Part Enter the disease, or shock, or heart failure. List	complications that cause on your cause on each I	d the death. Do not ine.	enter the mode of dyir	ng, such es cardiac (	or respiratory ar	rest,	Inte	proximate prvel Between set end Death	
/Medical Examiner	Immediate Cause (Finel disease or condition a. ACUTE MYOCARDIAL INFARCTION resulting in deeth)									
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yalcian: The secutificate director, pag	25. Was case referred to medica exeminer?				26. Place of Deat	n (Check only o	ne)			
사 등 는	1 ☐ Yes 2 No	Hospital:			4 LI Nursing Ho					
Attending P or death.  Sctor: After the funer the funer iffication:	27. Manner of Deeth  1 Netural 5 Pendir 2 Accident Investi	getion (Month, Da	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M			28d. Describe h	ow injury occur	red		
tal or Attanding P is after death.  In Director: After ted in by the funer.  Certification:	3 Suicide 6 Could 4 Homicide determ	ined   200. Place of In	jury - At home, farm lc. (Specify)	, street, factory, office			cation (Street and Number or Rural Route Number, ty or Town, State)			
To the Hospital or Attanding within 24 hours after death of the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner st	f examinetion end/o	eath occurred et the tir r investigation, in my o	ne, dete end plece, pinion, deeth occurr	and due to the ded et the time, d	cause(s) end ma dete end piece,	nner es steted and due to the	cause(s)	
Within To the comp	29b. Signature and titla of certific	^	20	29c. Licens	e number		29d. Data signed	d (Month, Day,	Year)	
10	> Mel	Lee		029	293		11/17	189		
17	30. Name and address of person 10313 CEORGIA		death (Item 23a) (Ty			MICHAE	L LINCOI			
State	31. Dete filed (Month, Day, Year)		ar's Signeture	20902	DIX.	TIL CUAL	P PIIACOI	41		
Registrar	NOV 2	2 1999		& spa	Ka)					

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### Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#10f perFHG777 11/22/99 FW Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day ALICE STRINGER 4b. City, Town, or Location of Death 1999 4c. County of Death 3:45 AM 4a Facility Nema (If not institution, giva street and number) Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar Months Days # Under 24 Hrs. 8. Data of Birth (Month, Day, Year) JAN . 10 , 1912 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) Hours 1 □ M 2 🖫 F 87 111-05-6914 MΔ Usual Residence of Decedent 10e Stata 10h Counts 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 8800 WALTHER BLVD. 21234 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14 Bace - American Indian Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: 1 □ Never Married 2 □ Married 1 ☐ Yas 2 XNo Specify: WHITE Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 PIANIST MUSIC 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) ZELIG NEVINS FANNIE (UNKNOWN) 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) EDWARD STRINGER / SON 5711 N. CHARLES STREET - BALTIMORE, MD 21210 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Removal from State HAR SINAI CEMETERY 11/17/99 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licepton 22. Nama end Addrass of Facility SOL LEVINSON & BROS., INC. user MD 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, For I. Effor the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Onsat and Death Immediate Cause (Finel disease or condition rasulting in death) CONGESTIVE HEART FAILURE Dua to (or as a consequenca of) CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lest Due to (or as a consequence of): Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in tha undarlying causa given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown CHRONIC ATRIAL FIBRILLATION 24b. Wara autopsy tindings eveilable prior to completion of cause of death? 24a. Was an autopsy ANEMIA 1 Yas 2 No 1 Yas 2 2KNo 25. Was casa refarred to medical examiner? 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: 1 tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 1 Netural 28c. tnjury et Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner physician and s the burial-transit be asscuted Box 68760. Physician/Medical 88 980 P.O. the th 6 Records, Completed has page certificate of Vital Be To this Certification: After t

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**Physician** 

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Examiner

**Funeral** 

Director

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Department of Health reportant: If Item 27

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Baltimore,

Division Hospital or Attending s after death.
I Director: After death of the further of the furth 24 hours To the Hosp within 24 ho To the Fune completely fi

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BOON-P. 31. Deta filed (Month, Day, Year) State Registrar

2 Accident

3 ☐ Suicide

29a. Cartifier

4 Homicide

(Check only one)

29b. Signetura end titla of confine

OWO

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

29c. License number D 37254

1 Yas 2 No

Certifying Physician: To the best of my knowledga, deeth occurred et tha tima, data and place, and dua to tha cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 199 16

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

7601 OSLER DRIVE, TOWSON, MARYLAND 21204

LIM,

1999

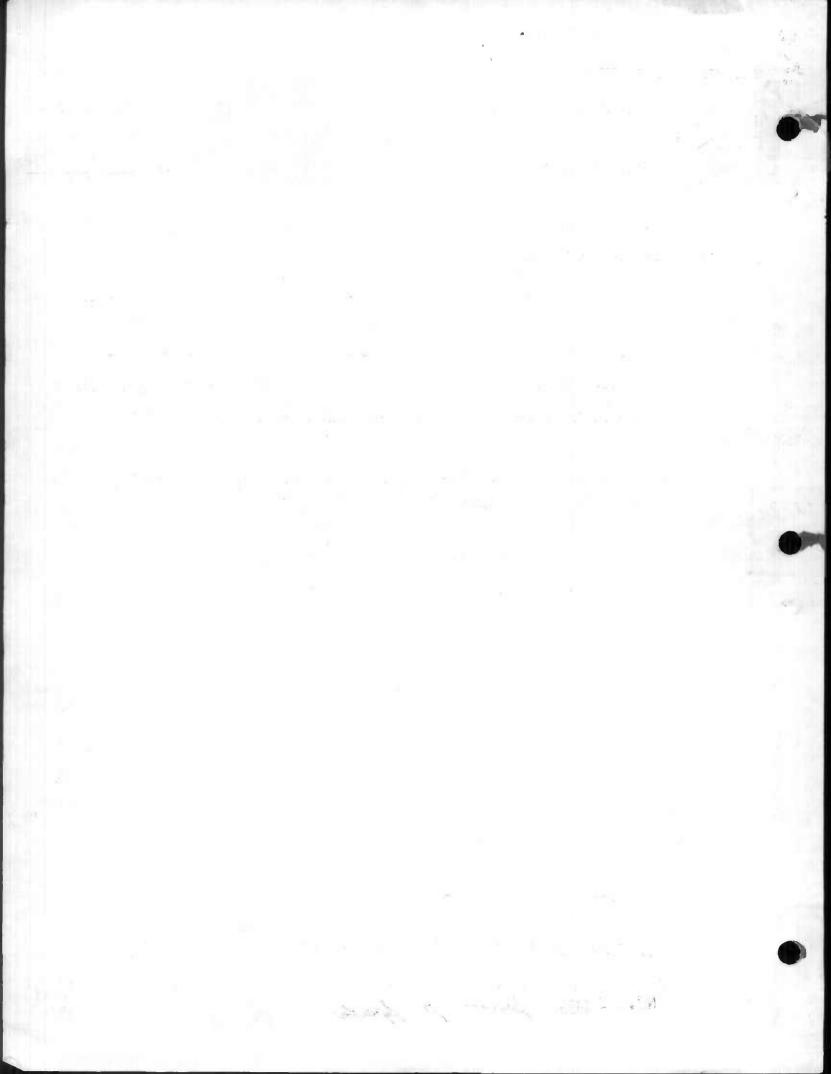
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Α	MENDED I	TEM	#9 PER FH G777 11/22/9	99 AH		e of Death	a ivientai my	Reg. No.	9 36429			
	Physic /Medi		1. Decedent's Name (First, Middle, Las	JUllive	an		2. Dete of De Month	O'7	3. Time of Deeth 23 25			
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	show ad at		Usuel Residence of Decedent  10e. State 10b. County	10c. C	ity, Town or Location	-			10d. Inside City Limits			
	deeth with the Maryland rms 23a or 28a-f show	ecto	MD N/A		Baltimore 10f. Zip	Code		10g. Citizen of V	Yes 2 No			
	ath with	a Di	954 Forest Sti	reet	21202	0000		_	JSA			
020	or Ite	by Funeral Director	11. Marital Status  1 ☐ Never Merried 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 □ Yes 2 Mo if Yes, Give Yeer or Detes:	J,S. 13. Was Deced	dent of HispenIc Origin? city Cuben, Mexicen, Pu No Specify:	(Specify Yes or Note to Ricen, etc.)	14. Rac Bled Specify	e · American Indian, ok, White, etc. White			
Maryland 21215-0020	rithin 72 ho	Completed	15. Decedent's Ed (Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usua (Give kind of workite. DO NOT us Labo	rk done during most of se retired)	working	16b. Kind of Bu	usiness/Industry			
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	od 2 sh lth end lth end 27 is m		19e. Informent's Neme/Reletionship (7 Brian Sullivar		19b. Mailing Address 3120 Kesw	(Street end Number or	Rure! Route Numb ltimore,					
Baltimore,	S 5 5 7		20e. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from State	Plece of Disposition (Nancemetery, cremetory or o	ne of	Dete		City or Town, State			
Balti	permit. Pe Departmer Important any injury		21. Signeture of Funeral Service Lordon Street Rolland Street Baltimore, Md 21201									
68760,	ificete be executed Wedical By physician and By the burial-trensit edical Examiner edical Examiner	Medical Examiner	23a. Patt. Enter the disease, of company, or heart feilure. List only of Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflieted events resulting in death) Lest	e. PD Due to (c. Due to (c.	or es e consequence of):	e of dying, such es care	diac or respiretory e	errest,	Approximate Intervel Between Onset end Death			
Records, P.O. Box	w requires thet the death cert been signed by the attendin should be deteched for use	ed by Physician/M	Pert II. Other significent conditions co		sulting in the underlying c	euse given in Pert I.	1	tobacco use con Yes 2□ No sen eutopsy	atribute to the cause of death?  3 Probably Aunknown  24b. Were autopsy findings eveilable prior to			
Reco	hes b	Completed					-		completion of ceuse of deeth?			
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	with Con	~	29b. Signature end title of certifier  Potture a	Musit	tmib.	DH12	na	29d. Date signed	Month, Dey, Year)			
	Sta	te	30. Name end address of person who co	ompleted ceuse of deeth (Iter  WY CON)  - 32. Registrar's Signi	m 23e) (Type, Print)	954	Form	est so	+. Baldi-			

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q AMEND#8 PER MD. G779 1-31-2000 J.A. Certificate of Death AMEND# 9 PER K.B. G777 11-20-99 J.A 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Vaar **Physician** 1999 8:53 pm Michael Nicholas October /Medical 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Greater Baltimore Medical Center Cowson Baltimore If Undar 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 6 Sex **Funeral** 10℃ M 2□ F Months Days Hours NONE **Director** Usual Rasidance of Dacedant with the Marylend 10e. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Marical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Havre de Grace Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Funeral 11 Heron Court 21078 USA death 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ② No If Yes, Give Year or Datas: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours after of Depertment of Haalth end Mentel Hygiena. If tem 27 is marked other than "natural", or fiss 117 Nevar Married 2 ☐ Married Maryland 21215-0020 1 Yas 2K No Specify: 29 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None None None 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Be Lo L. Harris Ronald Shawver Jov 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) 6.B.M.C., 6701 N. CHARLES, NIKKI CHIL COAT STAFF TOWSON, MD 21204 altimore, 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crametory or other place) Data 20c. Location - City or Town, Stata any Injury or o 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 □ Donation 5 □ Othar (Spacify) 10-30 BALTO MD 21202 GREEN MT. CREMATORY 21. Signatura of Funarel Service Licensea 22. Nama and Addrass of Facility & SONS CO. HW. JENKINS 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory afrast,

Approximate shock, or heart failura. List only one ceuse on each line. Approximate Intervel Between Onset end Daath **Physician** /Medical Immediate Cause (Finel disaasa or condition rasulting in daath) 20 min a. Extreme prematurity Examiner Dua to (or as a consequence of): Examiner certificata be axecuted physician and the burial-trans Sequentially list conditions, if eny, leading to immediata cause. Enter Undarlying Causa (Disaasa or injury Dua to (or as a consequence of): Physician/Medical that initieted events rasulting in daath) Last Due to (or es e consequence of): as use for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. datached signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Wera autopsy findings eveileble prior to complation of causa of death? 24e. Wes en eutopsy performed? Completed Dage 2 1 □ Vas 2 □ No 1 Yas 2 No certificata Division of Vital or Attanding Physician: director, 25. Wes casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) To 1 Yas 2⊠ No 1X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Data of Injury (Month, Day Year) funerel 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending after death. 1 Yas 2 No invastigation 2 Accident 6 ☐ Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) filled in by 4 Homicide 24 hours Hospital 29a. Cartifian 🔣 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. To the P within 2 29b. Signature and titla of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) D0051676

Registrar

State

31. Data filed (Month, Day, Year)
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6701 N. Charles Street Towson Maryland 21204

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEMS 20a- 22 PER FH G777 11/23/99 AH Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month **Physician** CLARA THOMPSON 15 1999 1250 PA NOV /Medical 4e Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Eastpoint Nursing ¢ Rehab Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)

June 9, 1932 Birthplace (Stata or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2/□F 67 Yrs. 218-28-5217 Director Usuel Residence of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Ves 2 No Director MD N/A Baltimore 25a-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be 1832 Ashland Ave 21215 USA Reme 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Yas 2 No If Yas, Give X Yaar or Dates: 1 Nevar Marriad 2 Married b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced "natural". Completed 18a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important; if hem 27 is marked other th any Injury or other traument Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be John Thompson Clara Lancaster 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Stenhouse/guardian unknown 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1XX Burial 2 Cremation 3 Removal from Stata NEW CATHEDRAL CEMETERY 11-19-99 BALTIMORE, MD 4 Donation 5 Othar (Specify) in state 21. Signature of Funeral Service Licensees . Wade, Director 22. Name and Address of Facility Board 655 W. Baltimore Street FRANCIS X GEORGE Baltimore, MD 21201 MARCH FUNERAL HOME 28a. Pert1. Entar tha disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Finel disaasa or condition rasulting in daath) COR Examiner physician end the burial-trensit Sequantially list conditions, if eny, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initieted evants rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. THEN PSEN 1 Yes 2 No 3 Probably 4 Unknown Schrana ģ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No certificata 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Alatural 5 Pending To the Hospital or Attendin within 24 hours after deeth. To the Funeral Director: Af 1 Yes 2 No investigation 2 Accidant 6 ☐ Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicida De Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian

State Registrar

(Check only one)

29b. Signatura and titla of certifiar

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Marthe K Moligle

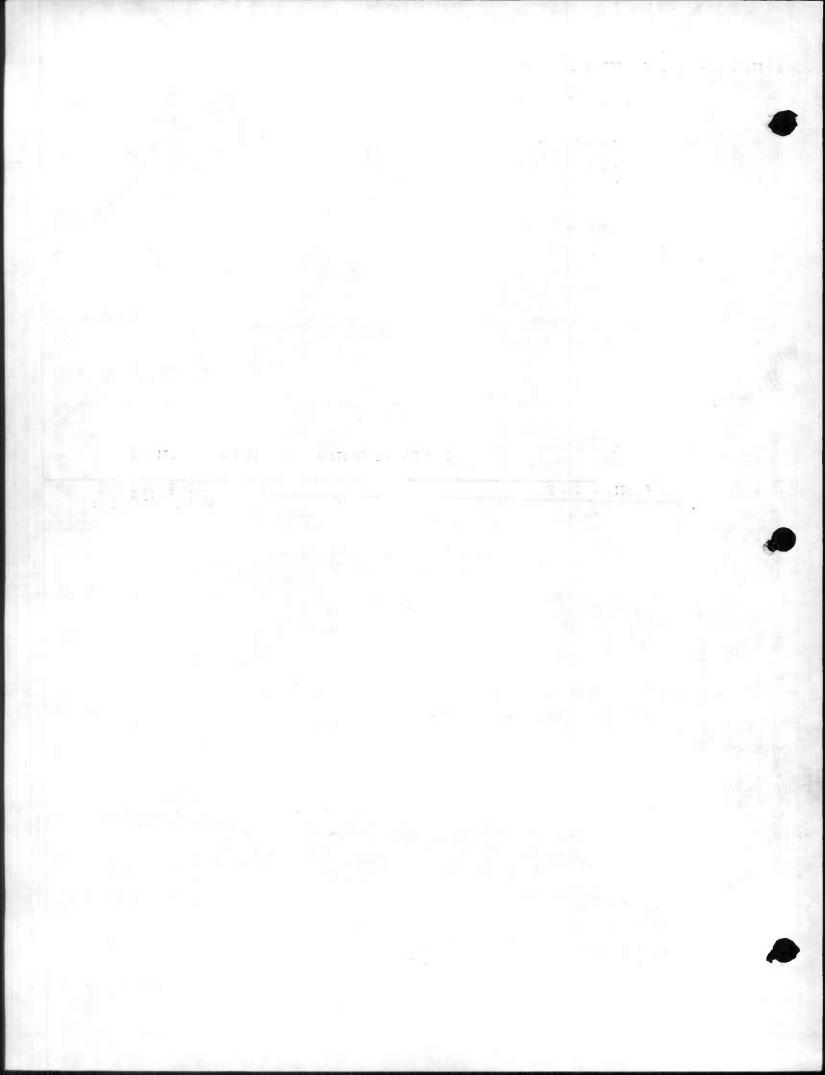
30. Name end addrass of person who completed causa of death (Item 23a) (Type, Print)

MONABNEY 31. Data filed (Month, Pay, Year) 32 /Registrer's Signature

5505 HOPKENI BAYVIEW MACL BALT NO 21224

45757

29d. Data signed (Month, Day, Year)

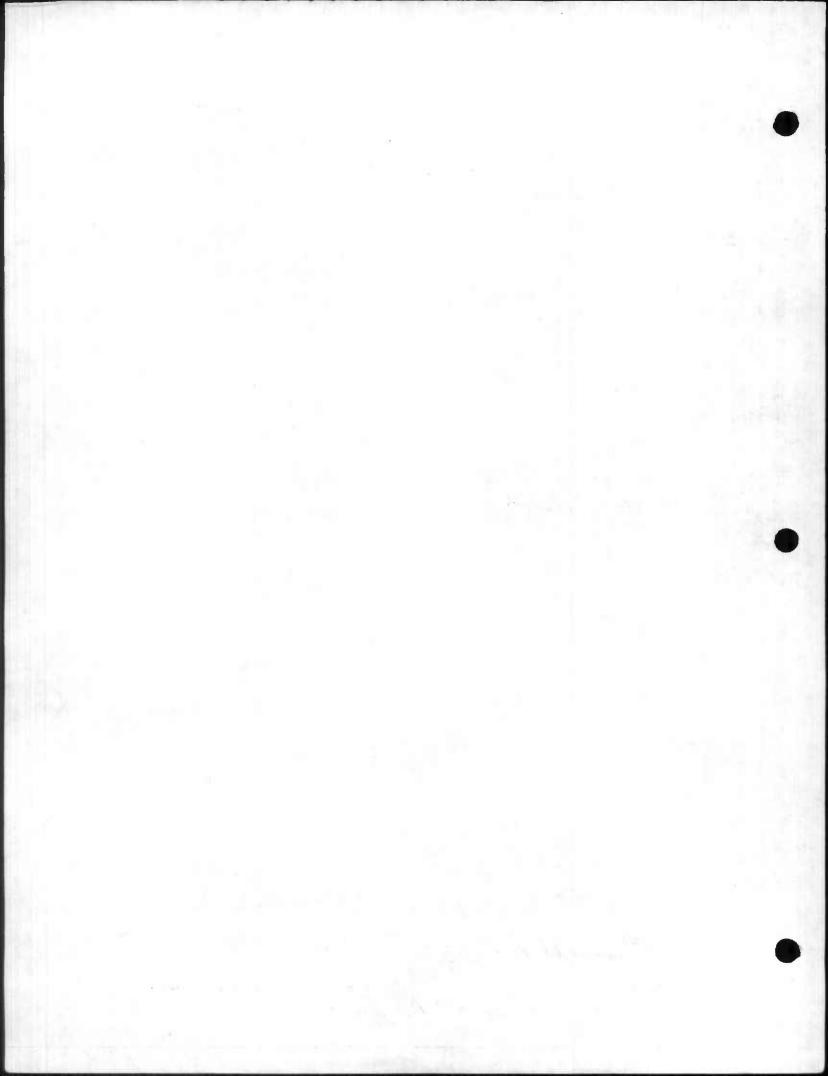


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unatu.	letec	15. Deceden (Specify only higher	nt's Education est grada complete	leted) 16a. Decedent's Usual (Give kind of work			k done	during most of wor	king	16b. Kind of B	usiness/Industry		
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nt of Health and Mental Hygiena. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	Mental Hyg arked otheratic event, TO Be C	17. Father's Nama (First, Middle, unknown	Last)		A.			18. Mother's Nan	ne (First, Middle known	, Maiden Sumar	na)		
ealth and In 27 Is ma	19a. Informant's Name/Ralations O.C.M.E.	ship (Type, Print)					eet Balt						
permit. Pages 1 and 2 Department of Health a Important: If Nem 27 Is any Injury or other tre		20a. Method of Disposition  1 Burial 2 Gramation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cametery, cremetory or other place)  20c. Location - City or T									City or Town, Stata		
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be assecuted ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (	or as a conseq	juence of):						-10	
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State Registrar

111 Penn Street, Baltimore, Maryland 21201



DHMH 16 Rev 6/95

ORIGINAL



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Physician AVID WILLIS NOVENBER /Medical 4a Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 940 Gastern1 Baltinue 1Sa/timare Johns Hopking Bayview If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Funeral Days Months Hours 1XM 2□ F June 3,1908 Director 214-01-2432 Maryland Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1⊠Yes 2□No Maryland N/A Baltimore City Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 1706 Charlotte Avenue 21224 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: þ 3 2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pegas 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic avent, the Medis once. Elementery/Secondary (0-12) College (1-4or 5+) Steel Industry 8 Years Foreman 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle Last) Be Anna Glossner Frank Willis 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1706 Charlotte Ave. Carolyn G. Willis (Daughter) Baltimore, Maryland 21224 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 11/20/1999 Baltimore, Maryland 21. Signature of Effineral Service Licensee 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ure Use on accordance of death. Do not enter the mode of dying, such as cardiac or respiratory arrast, ure Use only one cause on each line. Approximata Interval Between Onset and Death Part1. Entar the shock, or heart **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of). for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. the 2 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to Renal insufficiences 24a. Was an autopsy performed? Completed peeu completion of cause of death? 1 Yas 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified 25. Was case refarred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA 27. Mennar of Death 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be datarmined 3 ☐ Suicida 28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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72 hours efter

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

**DHMH 16 Rev 6/95** 

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31. Date filed (Month, Day, Year)

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30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 36435. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** THEODA L. WEINER 16 th 04:45 AM 1999 NOV /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE NURSING HOME BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 258-28-2487 1 M 2 X F Hours 93 Director OCT.28,1906 Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at N/A BALTIMORE 1X Yas 2 No Director 10a Street and Number 10g. Citizen of What Country? 10f. Zio Code 6 2801 TANEY ROAD 21209 23a U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herns : 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Maritel Stetus Bleck, White, etc. filed within 72 hours after Hygiene. Ither than "natural", or he 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: If Yes, Give Yeer or Detes: Specify: WHITE p 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 ahould be filed w. Department of Health and Mental Hygien. Important: if flem 27 is marked other that any Injury or other traumete. NURSE MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be TOM WILLIAM LEWIS LAVONIA **OGLESBY** 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELDON DOBRES / NEPHEW 4 CALYPSO COURT - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State BETH JACOB ANSHE VESHEAR 11/17/99 ROSEDALE, MD S ☐ Other (Specify) Funeral Service Liberal 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 usel Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one gause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final SEPSIS 7 days disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner DEHYDRATION 2 weeks physician and the bunal-transit Sequentielly fist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by i 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings evailable prior to completion of cause of death? been si Completed 24a. Wes en eutopsy page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation or Attending 1 Naturat 1 Yes 2 No daeth. Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide To the Hospital or Atla within 24 hours after da To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eversley m.D November 16th D005H73 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GERIATRIC CENTER, 2384 W. BELVEDERE, BALTIMORE MARYLAND

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registuar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 19 1999 1:56 PM E. Wienhold Nov. Dorothy 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEVERNA PARK ANNE ARUNDEL GENESIS ELDER CARE If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 20 F Months Days Yrs 76 216-14-3843 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE BROOKLYN PARK 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 301 GROVE PARK ROAD U.S.A. 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status Bleck, Whita, etc. 1 Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3€Widowed 4 Divorced Yaer or Detes: WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALESPERSON DEPARTMENT STORE 12 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) RUEBEN DAY LILLIAN McCAULEY 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) CURTIS M. WIENHOLD- SON 107 RUSTIC RIDGE, SEVERNA PARK, MD 21146 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Othar (Specify) GLEN HAVEN MEMORIAL PARK 11/22/99 GLEN BURNIE, MD 22. Name and Addrass of Facility SINGLETON FUNERAL HOME, PA. nature of Fundial Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Jeunoma Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (et es e consequence of): lalnutri Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? No De 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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Important: If Item 27 is
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**Physician** 

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Certification:

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1 Yes 26. Place of Deeth (Check only one)

28d. Describe how injury occurred

25. Wes case referred to medical examiner? Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 1 Naturel 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signetura end titla of certifier

6 Could not be determined

29c. License number

29d. Dete signed (Month, Day, Year) NOVEMBER 22, 1999

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

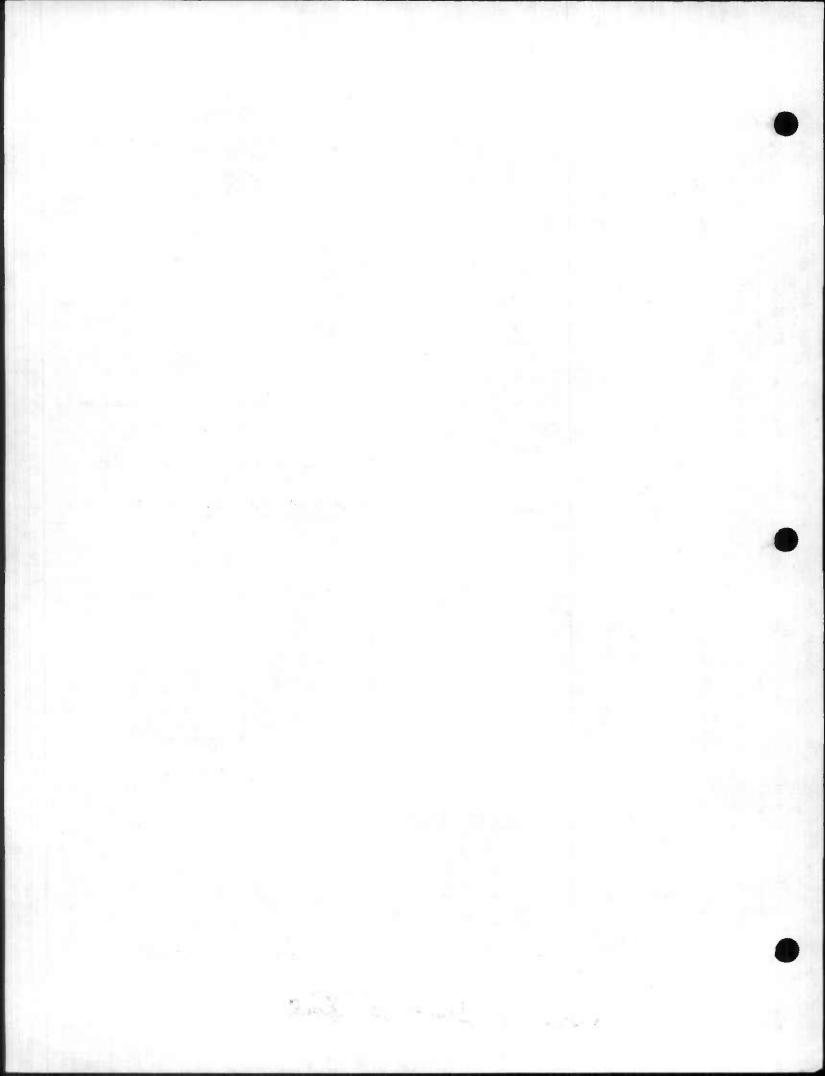
DR MIRZA NUSAIREE 7845 OAKWOOD ROAD #200\_ GLEN BURNIE, MD 21061

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

State Registra

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture NOV 2 2 1999

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 9,07 SHIRLEY WALKER November /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c, County of Deat Examiner Burnie Arundel Hospital Arunde 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Months PENNSYLVANIA 1□M 20 F 191-38-0242 53 1946 Director Usual Rasidance of Decedent 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 594 NOLBERRY DRIVE 21061 U.S.A. Funeral 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black White atc 1 ☐Yas 2 ☐ No 1964 If Yes, Giva 1060 filed within 72 hours efter 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: ò 1968 BLACK 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) REAL ESTATE AGENT REAL ESTATE 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be Pages 1 end 2 should be nent of Health end Mentel **OSCAR EDWARDS** ROSIE LEE BATLEY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Important: If item 27 is any injury or other tra once. WARREN WALKER, SR .- HUSBAND 594 NOLBERRY DRIVE, GLEN BURNIE, MD 21061 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Department GLEN HAVEN MEMORIAL PARK! 11/23/99 GLEN BURNIE, MD 22. Nama and Address of Facility SINGLETON FUNERAL HOME, PA. 21. Signatura of Funaral Sarvice Licensee 1 SECOND AVE., S.W., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician sthe burial Box 68760, Dua to (or as a consequence of) 980 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contributa to the cause of death? Records, P.O. 1 Yes 2 10 3 Probably 4 Unknown by 24b. Ware autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 20 No 1 Yas 1 Tyas 2 No Division of Vitai or Attending Physician: 8 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To N Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Data of tnjury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Natural 5 Pending invastigation To the Mospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner as taled. | Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signatura and titla of certifiar

31 Date filed (Month, Day, Year)

NOV

30. Nama and addrage of person who complated causa of death (Item 23a) (Type, Print)

301

32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

Drive

29c. License number

Burne,

MD.

29d. Data signed (Month, Day, Year)

18



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23:49 PAUL. ZIPPERT November 15 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) SEP • 9,1920 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 2. spert 217-16-3999 11 M 2□ F 79 Yrs GERMANY Director Usual Residence of Decedent deeth with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 No Director BALTIMORE REISTERSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23s. 564 KENNINGTON ROAD 21136 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Marviand 21215-0020 WWII 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bustness/Industry Elementary/Secondary (0-12) College (1-4or 5+) BRACEMAKER MEDICAL EQUIPMENT permit. Peges 1 end 2 should be file.
Deperment of Heelth and Mentel Hygi.
Important: if them 27 is marked eny injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 MAX ZIPPERT HELENE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BERTL ZIPPERT / WIFE 564 KENNINGTON ROAD - REISTERSTOWN, MD 21136 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 11/18/99 CHEVRA AHAVAS CHESED 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** bleeding /Medical Immediate Cause (Final GI 2 days disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 Yes 2 No Records. P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director. Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 28b. Time of After 1 Natural 5 Pending Investigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident efter deeth Director: 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide hours • Funerel 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of potton who completed cause of death (Item 23e) (Type, Print)

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Registrar

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32. Registrar's Signature

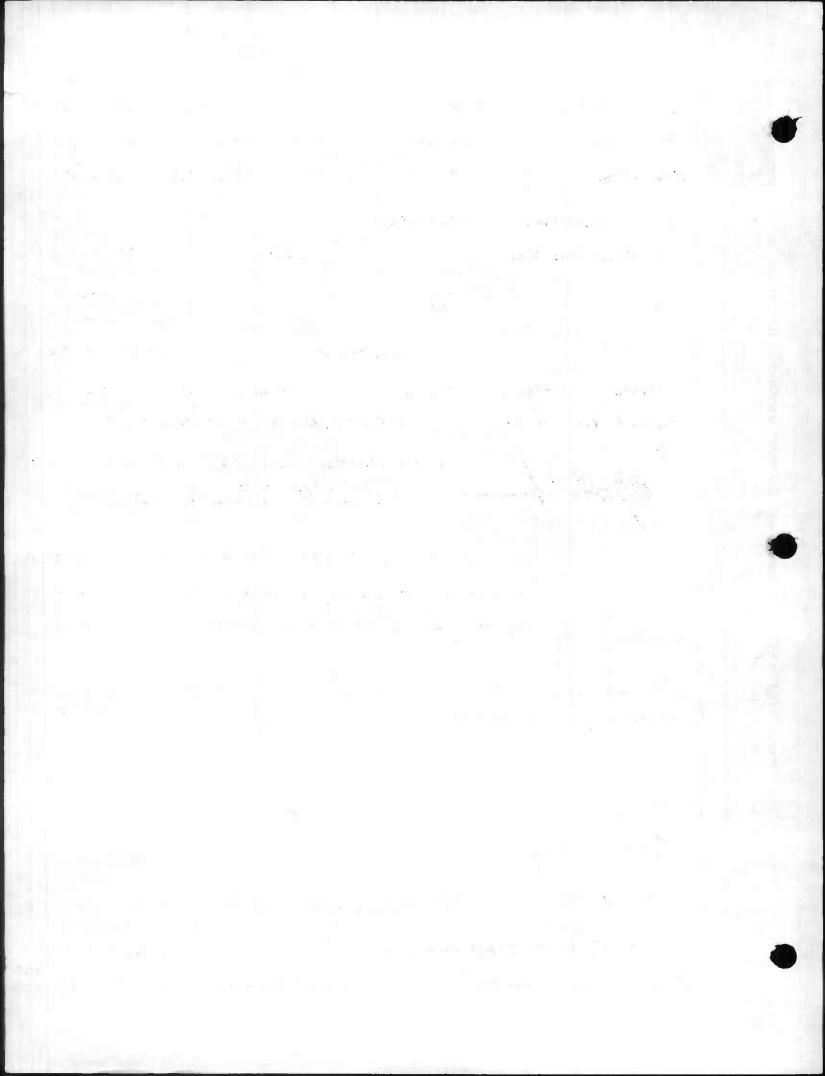
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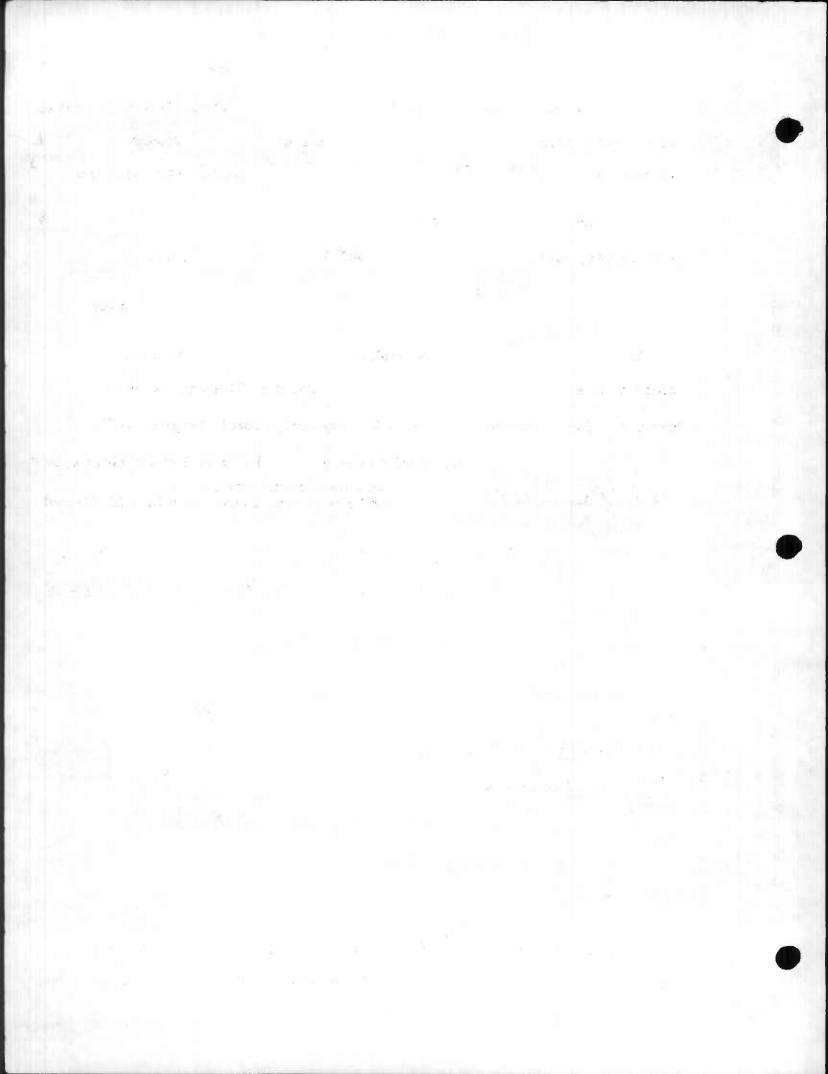
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ysician: The law s certificete hes director, page 2 To Be Comp						1□ Y	as 2 No	1 U Y	as 2□ No	
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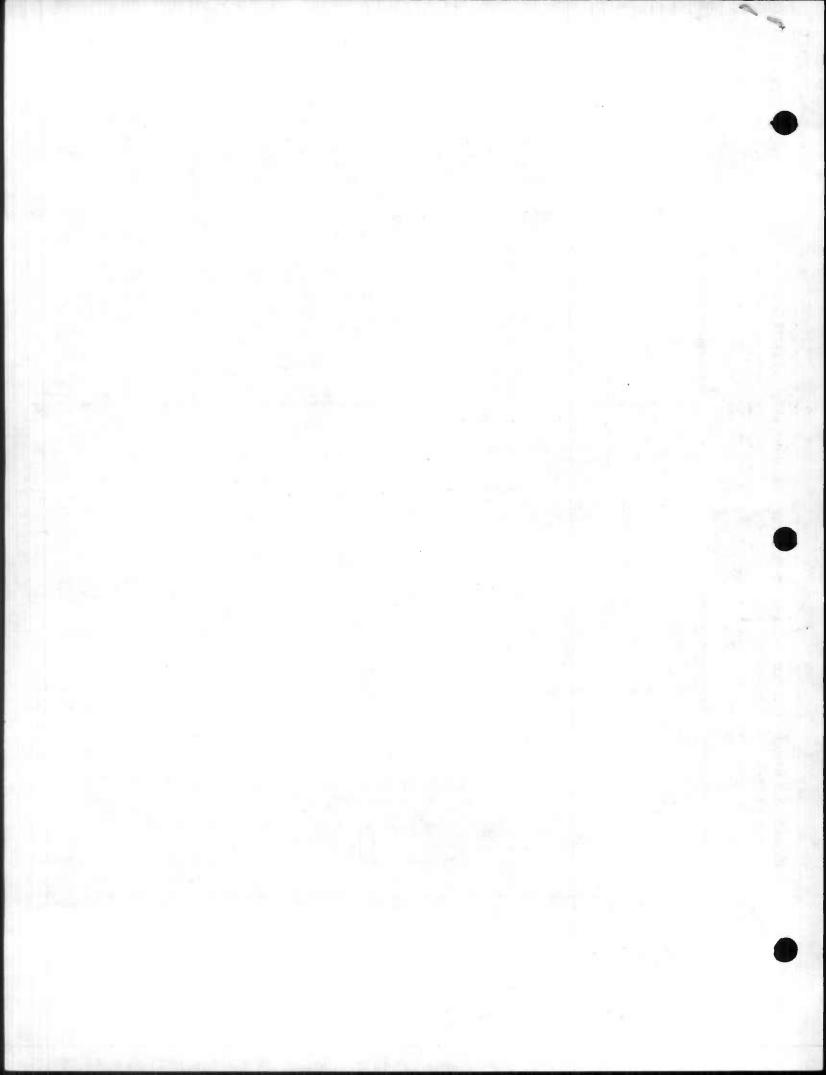
State of Maryland / Department of Health and Mental Hygiene 36442 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year CARL RUDELL **ANGLEBERGER** October 24, 1999 2:23 P.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M M 2 F 220-16-0794 76 Director Aug. 7, 1923 Maryland Usuel Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Keymar 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 11713-A, Woodsboro Pike 21757 United States death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or itel in yor other traumatic avant, the Medical Empirical ury or other traumatic avant, the Medical Empirical ury 1 Never Merried 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Dairy Farmer Own Dairy Farm 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Carl W. Angleberger Virgie Ann Dodd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 11713-A, Woodsboro Pike/ Keymar, MD Marian Nash Angleberger / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State permit. Page Department of Important: If any Injury or once. 10-27-99 Frederick, Maryland Mount Olivet Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Perf. Errey the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory one ceuse on each line. Approximete Interval Between Onset end Death Physician /Medical Immediete Cause /Final Gunshot wound to the head 3 days disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Sepsis physician and s the burial-transit that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of) usa ò Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Lung Cancer signed I Records. à The law requires should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital after death.

Olssetor: After this carifica 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funaral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Neturel Oct. 21,99 7:20 AM 1□Yes 2周No Self inflicted gun shot 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) à 2 To the Hospital of within 24 hours at To the Funeral D completely filled in 11713-A, Woodsboro Pike 29a. Certifier 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. edical (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 35164 October 26, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zarick Jr., 1080 W. Andrew Patrick St./ Frederick, Md 21703 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

Registrar

2 8 1999

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year NOVEMBER 3, 1999 Physician MABEL **ADAMS** ALICE 3:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 24 Hrs. Hours | Min. If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Year) Oct. 28, 1901 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 98 Months 10 M 20XF Nebraska 239-62-0338 Director Usual Residence of Decedent the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show shipury or other traumatic avant, the Medical Examinat must be notified at page. 10b. County 10c. City. Town or Location 10d. Inside City Limits Thurmont 1 ☐ Yes 2 ☐ No Frederick Maryland Directo 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code U.S.A. 21788 7561 Utica Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🖾 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nursing 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 John David Carlson Ruby Hixson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 132 Clipper Court, Kill Devil Hills, N.C. 27948 Mrs. Marilyn Hinson, Daughter 20b. Place of Disposition (Name of 20a\_Mathod of Disposition

AD Buriat 2 Cremation 3 Removal from State 20c. Location - City or Town, Stete Date Resthaven Memorial Cardens, Nov. 5, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basiord P.A. Funeral Home M00255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Cerebrovos attending physicien and for use as the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. P.O. 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) To. Hospitel: 1X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t a or Attending P s after death. i Director: After I 150 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital of 124 hours at Puneral D 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Villa 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Toluno MD 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MO Suite 204 Tane.

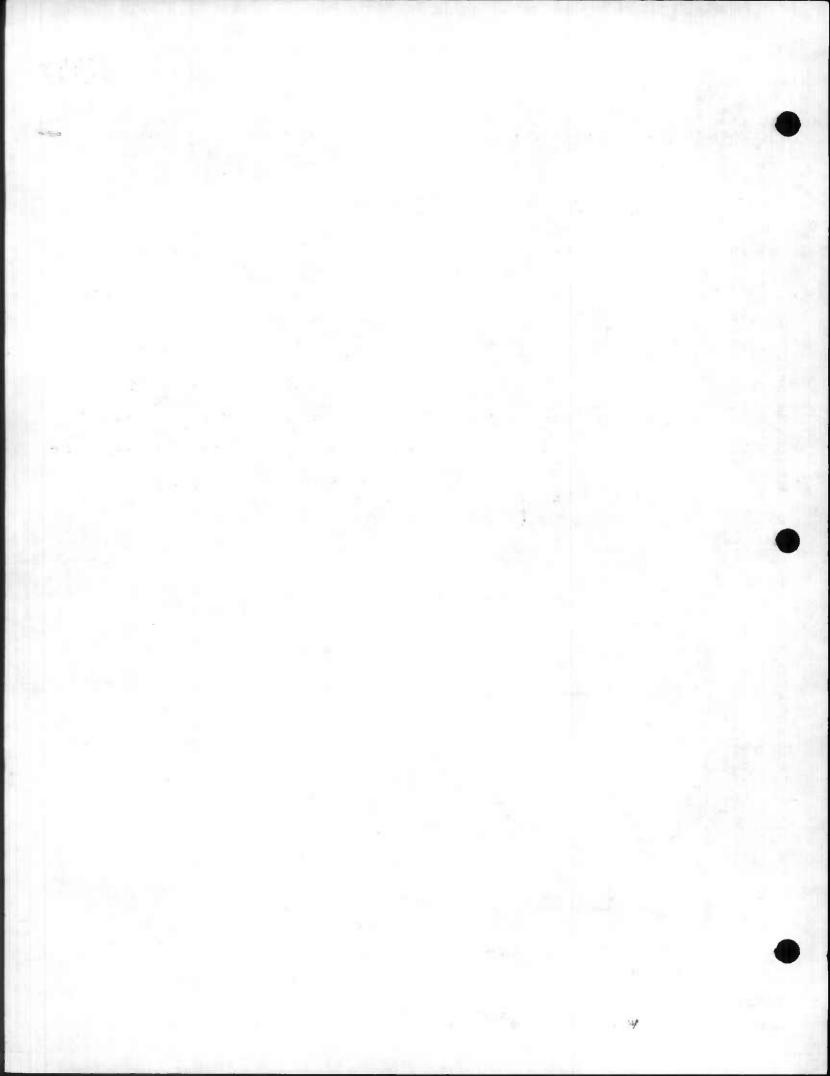
DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

0 5 1999

32. Augistror's Signature



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elizabeth Julianna Blessing NOV 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bel Air Harford Mariner Health of Bel Air If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□M 2√2F Months Deys Hours Yrs. 91 March 7, 1908 Maryland 215-10-9724 Usual Residence of Decedent 10c. City, Town or Location 10a Stete 10b County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Forest Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? #1 Colgate Drive 21050 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: \$☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Borchard Margaret U/K U/K Stumpner George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 Cass Drive, Bel Air, Maryland 21015 Dennis C. Blessing (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Nov.8,1999 Baltimore, Maryland Gardens of Faith 21. Signature of Funeral Se 22. Name and Address of Facility Howard K. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 enter the mode of dying, such as cardiec or respiretory arest, ADDIOXIMETE Approximete Interval Between Onset and Death Urusipsis ane week Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) examiner' 1□ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28c. Injury et Work? 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760 or Attending Physician;

physiclan end the burial-transit signed by the a s certificate has t diractor, this After Director: within 24 hours eft To the Funeral DI completely filled In

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

**Funeral** 

Director

filed within 72 hours aftar death with the Marylend

Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours eftar death with the Marylan Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other treumnite event, the Wedical Examiner must be neuficed anonce.

**Physician** 

/Medical

**Examiner** 

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

the

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29c. License number

29d. Date signed (Month, Dey, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

D34652

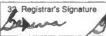
November 5, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

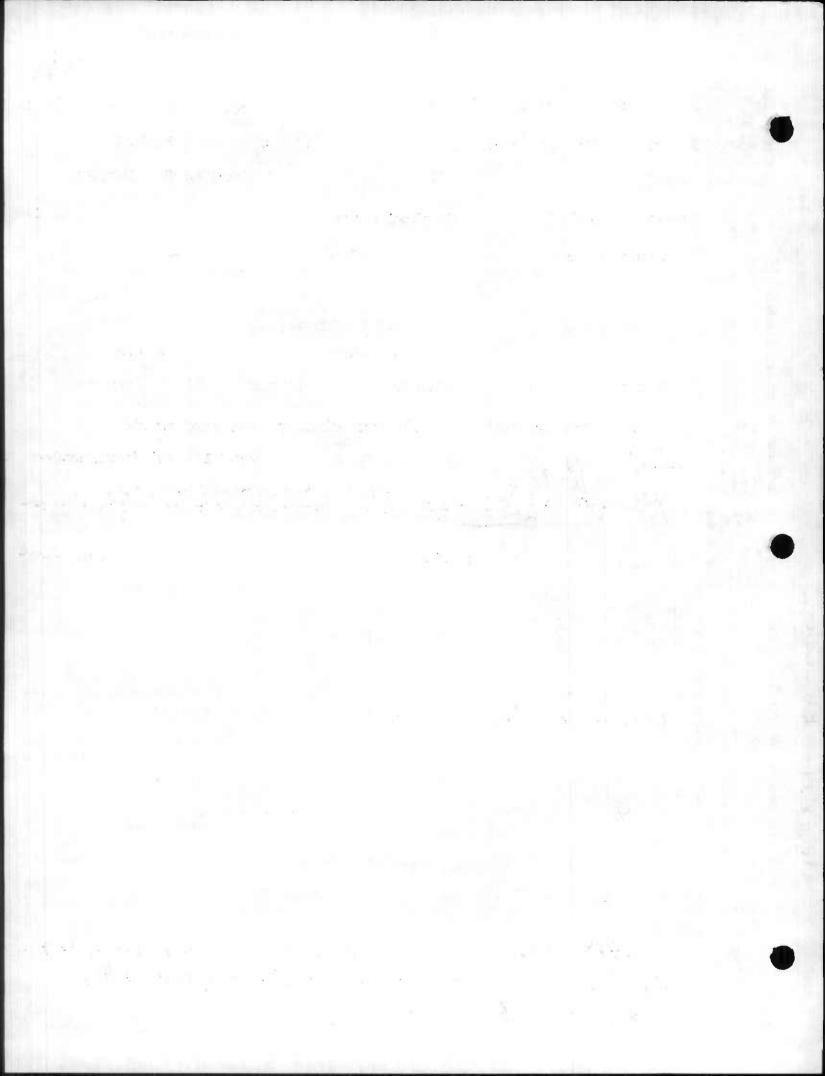
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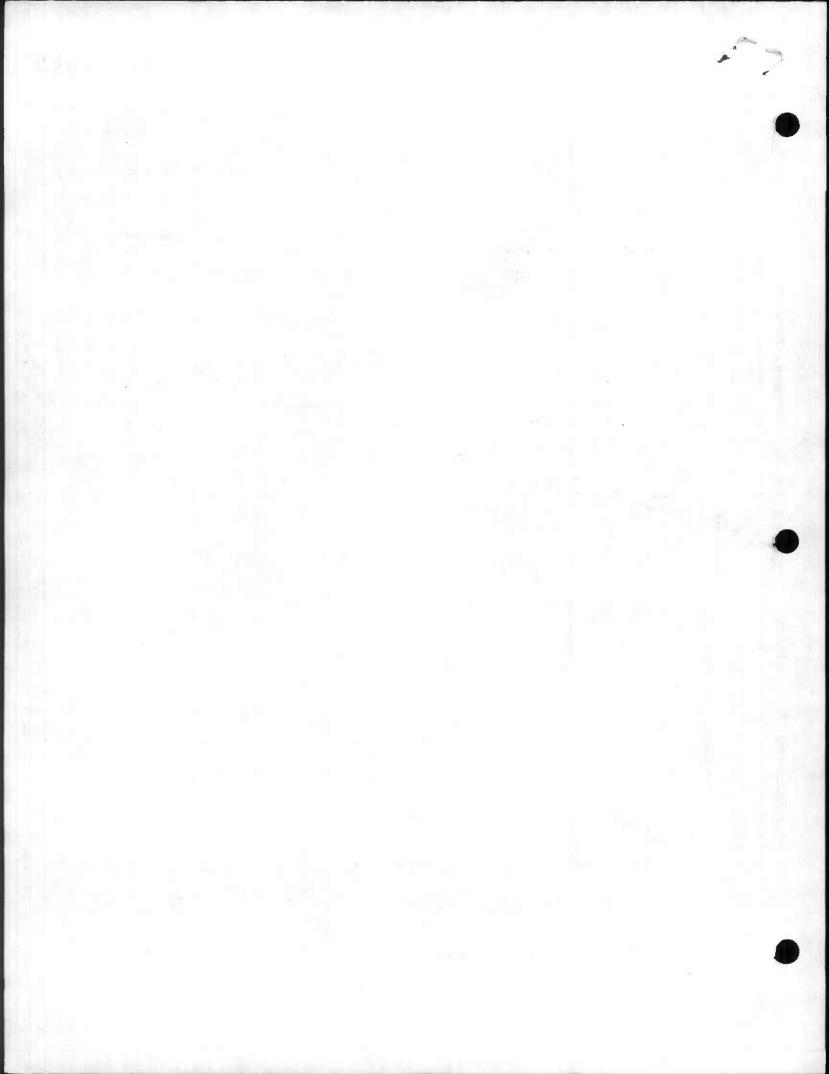
31. Date filed (Month, Day, Year) NOV 0 8 1999



28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)



, 4		State of Ma	•	epartme Certifica			Mental Hy	giene 9	9 36	5445		
Physician /Medical	Decedent's Neme (First, Middle, Last     Carl Le	eon BAKE	R				2. Deta of De Month October	Dey	Yeer	Tima of Death 4:48 PM		
Examiner	4s Facility Name (If not institution, give Washington County		4b. City, Town, o Hagers	r Location of Deatl	4c. County of Deeth Washington							
Funeral Director	Social Security Number     6. Se		e (In yrs. last birtl 48 y	Months	or 1 Year Days	If Under 24 Hr Hours Min	8. Date of Bir	th	9. Birthplace (	(State or Foreign		
ehow de la	Usual Residence of Decedent  10a. Stata 10b. County  Maryland Washing	ton	10c. City, Town	or Location Stown					10d. In	nside City Limits		
deeth with the Maryland ime 23s or 28s-f show it must be notified at neral Director	10e. Street and Number 312 East Franklin		1.0802		ip Code	21740		10g. Citizen of Whet Country? U.S.A.				
P 20 5	11. Merital Status  1 2 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Giva 1 □ Yes 2 ☒ No Specify:					Blec	e - American Inc k, Whita, etc. white			
	15. Decedent's Edu (Specify only highest grad	le completed)						16b. Kind of Bu		,		
Battimore, Maryland 212: permit. Peges 1 end 2 should be filed withir Department of Heelth end Mental Hyglene. Important: If Item 27 is marked other than eny injury or other treumatic event, the Mental	17. Father's Name (First, Middle, Last)	on Baker		042	Bruc	eme (First, Middle Carle		е)				
ond 2 should be self and N n 27 ie man	19a. Informant's Neme/Reletionship (7) Mrs. Anna Yost/sis						Rural Route Numb					
Baltimore, semit. Peges 1 er Department of Hear mportant: if Hear in Hollary or other ince	20a. Method of Disposition  1 Burial 2 Cremetion 3 F  4 Donation 5 Other (Specify)		The second secon	Disposition (Na , crematory or town Cr	other pla		Nov. 1,	20c. Location -				
Demit. Depentiment	21. Signature of Fuperal Service Licens	min	in				Minnich l			Land 2174		
Physician	23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	d the death. Do no	ot enter the mo	ode of dyin	ng, such es cardi	ac or raspiratory a	rrast,	Inter	roximate rval Between set and Death		
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	Arte	cioscle Due to (or es a c			rt Dise	ease		ears			
executed on end del-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or es a consequence of):										
is, P.O. BOX 68/60, es that the death certificate be executed tipned by the estending physicien and be deteched for use as the burist-transit by Physician/Medical Examir	Cause (Disease or injury that initieted events resulting in death) Last	C. Due to (or es e consequence of):  d										
of the death certification of the estending personal for use as Physician/Mer	Part II. Other significant conditions cor	ntributing to death b	buting to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of death			
s, T.O. gned by the be deteche by Phys							1)(1)	¥ee 2□ No	3 Probably	4 □ Unknown		
requir requir sens should			24						eveileble	utopsy findings le prior to tion of cause n?		
VITAL MEGION: The law certificate has billinector, page 2 and 0 Be Compile							10	Yes 2 No	1 ☐ Yes	s 2□ No		
OT VICE Physicien: this certific rel director,	25. Was case referred to medical examiner?	lospitel:	ent 2 ER/Out	patient 3CXC	OA Ott	voc	eeth (Check only		er (Snecily)			
or Attending Physicien: T or Attending Physicien: T birector: After this certifical I in by the funeral director, p ertification: To Be C	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Inju (Month, Da)			28c. Inju		_	ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
To the Hospital or Attending Physical Authors attended to the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, fen c. (Specify)	m, street, fecto		281. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital within 24 hours e To the Funeral D completely filled		Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner aminer: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and duand manner stated.										
To the troop to the troop to the troop tro	29b. Signature and title of certifier	0		25	9c. Licens	e number		29d. Date signed	(Month, Dey,	Year)		
	20 Non and others of any	, Ditte	200	Summa Parkers	DO	1062		Novembe	er 1, 19	999		
	30. Name and eddress of person who co Edward W. Ditto,				ashir	ngton St	. Hager	stown, M	D 217	740		
State Registrar	31. Date filed (Month, Day, Year) NOV 0 2 199		er's Signetura	1.	board							



State of Maryland / Department of Health and Mental Hygiene 36446 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Year Month **Physician** Delores Arlene BINKLEY OCTOBER 30.1999 3:18 A.M /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days 1 M 2 XF Months Hours 68 Aug. 2, 1931 Director 220-28-8166 Maryland Usual Residence of Deceden 10a. Stata 10c. City. Town or Location 10d. toside City Limits Items 23s or 26s-f show 10b. County 1 ☐ Yas 2 ☐ No Director Maryland Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14044 Village Mill Drive 21767 USA Funeral 11. Maritat Status 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. e filed within 72 hours effer al Hygiene. other than "natural", or Ite 1 ☐ Yes 2 ② No If Yas, Giva Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify. white Specify: þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 0 assemb1v aircraft permit. Pages 1 and 2 should be file Department of Health end Mental Hy, Important: If Itam 27 is marked oths any Injury or other traumatic evant, bhos. 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Frank Roger Hamby Rosa Mae Wilson 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Darryl L. Binkley - son 7538 McClellan Ave., Boonsboro, Maryland 21713 20b. Place of Disposition (Nama of cematary, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 11/2/99 Hagerstown, Maryland 22. Nama and Addrass of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd., Hagerstown, Md. 21740 Unne 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Daath **Physician** tmmediata Causa (Final diseasa or condition resulting in death) AORTIC STENOSIS MONTHS /Medical Examiner Dua to (or as a consequenca of): Examiner AORTIC VALVE REPLACEMENT DAYS sician and burial-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a CORONARY ARTERY BYPASS SURGERY Box 68760. Physician/Medical Dua to (or as a consequence of) 89 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? the 3 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy tindings available prior to complation of causa of death? Completed 24a. Was an autopsy has 1 Yas 2□ No 1. Yes 2□ No certificate To the Hospital or Attanding Physician: within 24 hours after death.

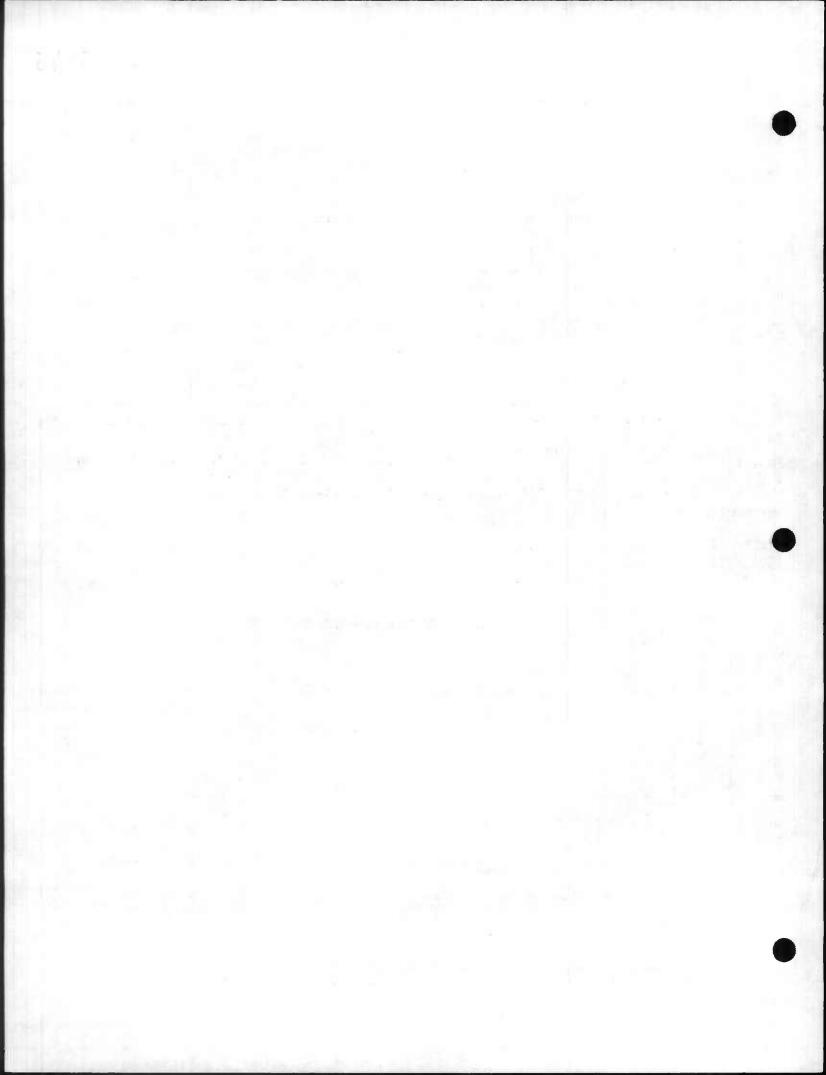
To the Funeral Diractor: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No P 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending tnjury 1 Yes 2 No invastigation 2 Accident 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred et the tima, date and place, and due to the cause(s) Medical 29e. Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number Paltologi 8V 10-30-99 D28244 30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print) FOWZIA TAQI, M. M., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

NOV 0 2 1999



State of Maryland / Department of Health and Mental Hygiene 36447 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Ponth **Physician** STANLEY 1:50 P /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner LORIEN COLUMBIA, MD HOWARD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 10XM 20 F Yrs. 220-30-2357 70 Aug 1, 1929 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or flems 23s or 28s-f show other traumstic event, the Madical Examiner must be profited at 1 TYes 28 No Director Maryland Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5001 Orchard Drive 21043 United States Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 █No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify If Yes, Give Year or Detes: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Depertment of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Inj Elementery/Secondary (0-12) College (1-4or 5+) unknown Diesel Mechanic Trucking 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John H. Barth Lilly M. Porter ည 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5001 Orchard Drive Ellicott City, MD 21043 Mae M. Barth/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10-18-99 Elkridge, MD Meadowridge Cemetery 22. Name end Address of Fecility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licarisee home 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset end Death **Physician** Strolio /Medical Immediete Cause (Final diseese or condition resulting in death) Examiner rcular dereau attending physicien end for use es the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Box 68760, Physician/Medical Due to (gras a consequence Messure Part ff. Other significant conditions confributing to death but not resulting in the underlying cause given in Part f 23b. Did tobacco use contribute to the cause of death? P.O. signed by i 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 PNo 1 ☐ Yes 2 ☐ No certificata 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28a. Dete of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury et Work? After Attending 1 Naturel 5 Pending Investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated. cai 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type Print) 30. Name and address of person with comp vas Rd OLODRUSETZ 9501

Registrar **DHMH 16 Rev 6/95** 

State

31. Dete filed (Month, Dey, Year)

32. Registrar's Signature

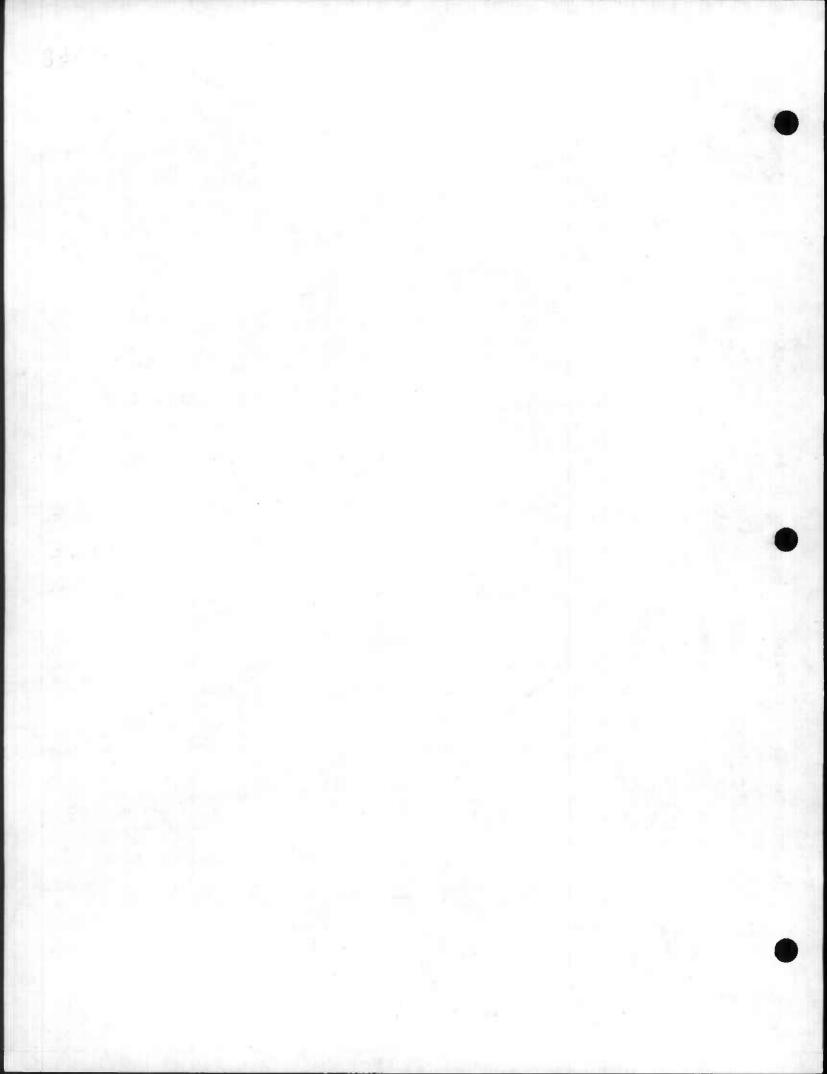
1999

STRICE L. SHARM COLUMN TO THE REAL STRICE.

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

	Decedent's Name (First, Middle, Last)	State of Maryla		rtificate of	Death		Reg. No.	36448
Physician	John	Wesley	D.			Month October	Dey	Yeer 999 2:50 AM
/Medical	4a Facility Name (If not institution, give s		D	ryant	lb. City, Town, or Lo			
Examiner		morial Hosp	ital		Frederi	ck	Frede	erick
Funeral	5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Dete of Birt (Month, De)		Birthplece (State or Foreign Country)
Director	233-09-7995 15	M 2□ F	84 Yrs.	Months Days	Hours Min.	May 30		Kentucky
Aaryland F ehow	10a. State 10b. County S. Carolina You		City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
or 28e-f e	10e. Street and Number	. K	TOIL .	10f. Zip Code			10g. Citizen of W	That Country?
A P P P P P P P P P P P P P P P P P P P	116 Summersby	Street		2	9715		United	States
ther death viter death viter death viter met		2. Was Decedent Ever in	U,S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,
by S.	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1		1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	rican, etc.)	100	White, etc.
22 ho	15. Decedent's Educ	eation	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of But	siness/Industry
21213-0 lad within 72 hor lyglens. The fraction ft, fraction Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work	.3	01	1 71
CO FEET N		4	Adm	inistrati		(Fig. ) by the		al Plant
B S S S S S S S S S S S S S S S S S S S	17. Father's Name (First, Middle, Last)				18. Mother's Name			
To To			yant, S		Elizab and Number or Run			Moore,
Mand Hand	19a, Informant's Name/Relationship (Typ					error ventere		
the Hand	Karl A. Dehn / nep			r Teasant osition (Name of matory or other place	Grove Dr	Dete Dete		City or Town, Stele
Galtimore, semit. Pages 1 at 20-partment of Heal moorlant: If New 3 any Injury or other and	1 Burial 2 □ Cremetion 3 □ Re	emoval from State		matory or other plac ta Cemete		1_1_00		ld, W.Virginia
Parties P	4 Donation 5 Other (Specify)  21. Signature of Funeral Service License			2. Name and Addre			Funeral	
D SE SE	D. 10	7/			. 50			
	23a. Part I. Epine the dimens, or complice shock or heart failure. List only on	cations that caused the de		- A	umtown Pi			MD. 21702 Approximele
Physician	shock or heart failure. List only on	e cause on each line.						tnterval Between Onset end Death
/Medical	Immediate Cause (Final	ASPIRATIO	I PN	FUMON A				Iwic
Examiner	disease or condition resulting in death)		(or as e conse		3			1000
		A	EUKEM					YR.
cate be assected physicien and site burlaturanit atte burlaturanit	Sequentially list conditions,		(or es e consec	1/ 4				
G a sign	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							1
ficate be aw physicien as the burial- edical Ex	that initiated events resulting in death) Last							
death certification of for use as								
. 0 00 =	Part II. Other significant conditions conf	tributing to death but not r	resulting in the u	inderlying causa giv	ren in Part I.			tribute to the cause of death?
						10	Yes 2 No	3 Probably 4 Unknown
Hecords, F.C. he law requires that the has been signed by th tgs 2 should be detach ompleted by Phys							en eutopsy	24b. Were eutopsy tindings
The law require pate has been all page 2 should Completed						perlo	rmed?	eveilable prior to completion of cause of daeth?
The lay						101	res 210 No	1 ☐ Yes 2 ☐ No
= F # a 0	25. Was case referred to medical				26. Place of Deat			10 165 20 140
Of Vital Ke Physicien: The lav this certificate has rai director, paga 2 i: To Be Comp	examiner?	ospital: 1 Ninpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er _		dence 6 Othe	er (Snacify)
0 5 5 5	27. Manner of Death	28a. Date of Injury	28b. Time o	100			now injury occurr	
Manding the time funding the f	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t homa, farm, st	reet, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
To the Hoopital or within 24 hours and To the Funest Discompletely filled in completely filled in		ician: To the best of my k er: On the basis of exami and manner stated.						
To the sound	29b. Signature and title of certifier			29c. Licens	e number			(Month, Dey, Year)
	Mary Nano	~ ms		DA	11077		OCTOBER	28, 1999
	30. Name and address of person who con NEIL WAZAVEKAL		tem 23a) (Type,	Print)	+ Faron	ACK MT	2170	)2_
State	31. Date filed (Month, Day, Year)	32. Bégistrar's Sig		301-	1 .010044	100		•
Registrar	OCT 2 9 1999		9	don	1/2/			

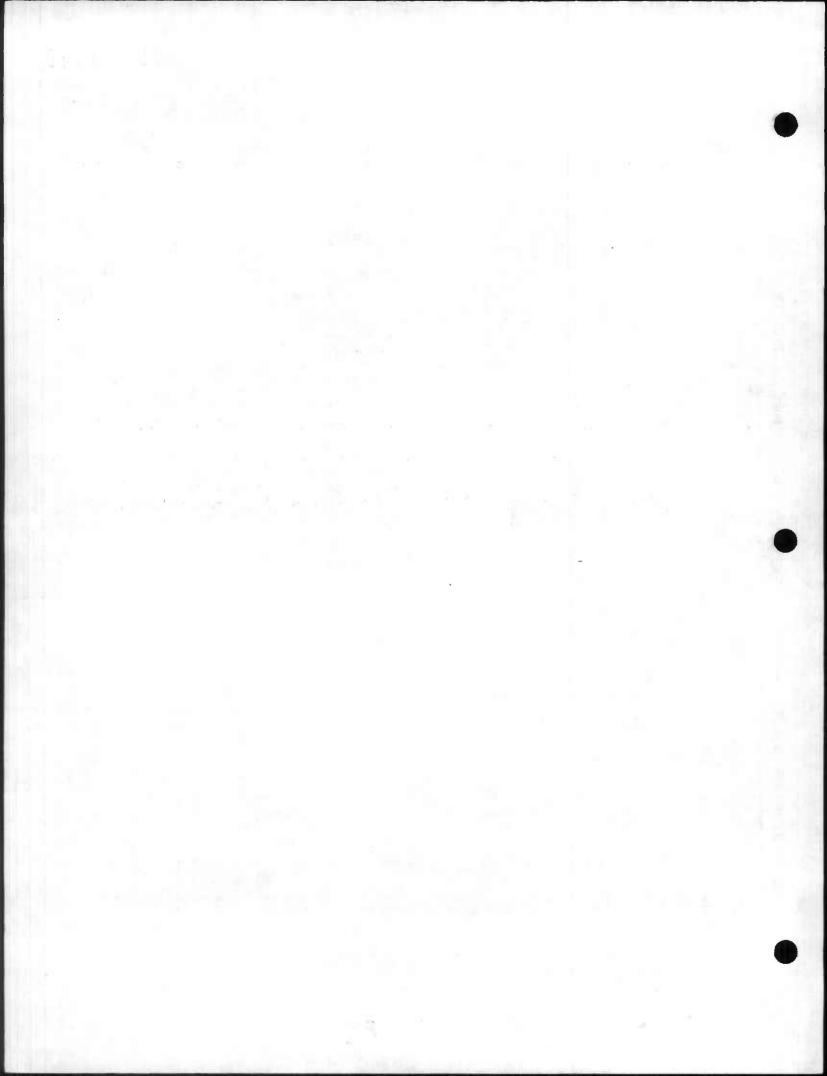
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene o

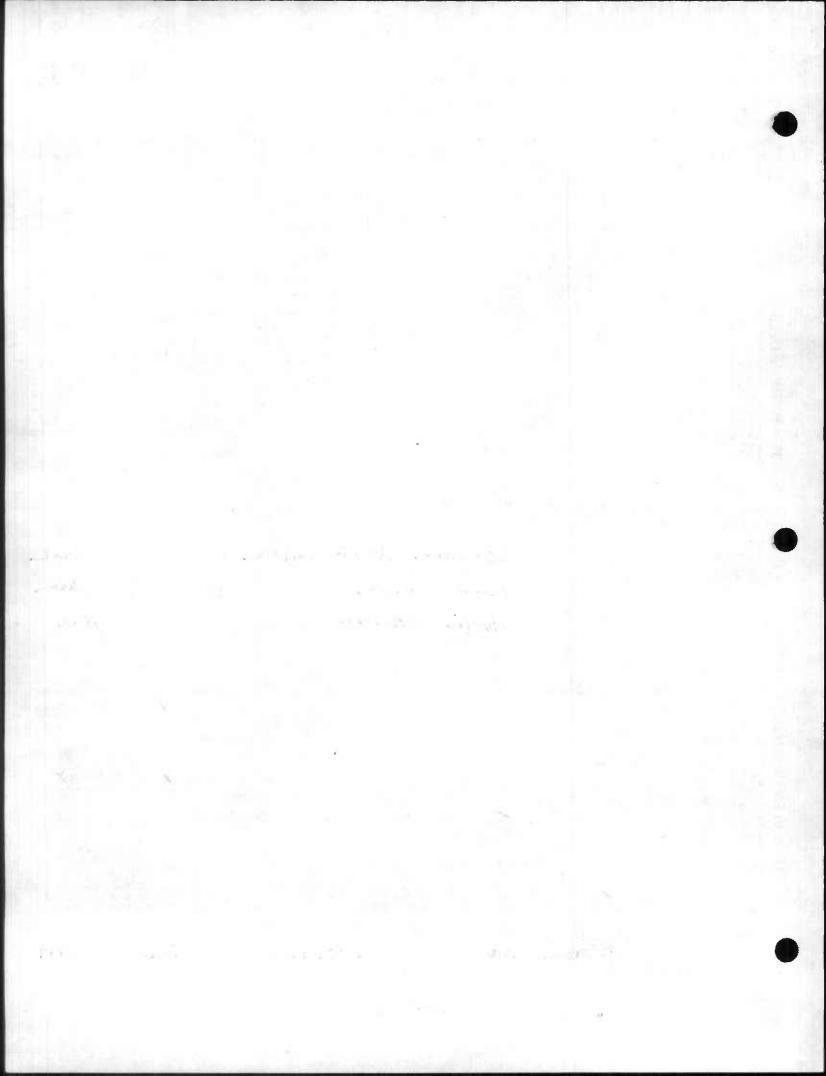
			Ce	rtificate of	Death	Re	g. No.	36449	
ı	Physician	1. Decedent's Nama (First, Middla, Last)  Edna Marie Buhr	man			2. Data of Death Month November		3. Time of Death 10:30 PM	
	/Medical Examiner	4a Facility Nama (II not institution, giva street and num College View Center	ber)	-	46. City, Town, or Lo Frederic	cation of Death	4c. County of	of Death	
	Funeral Director	5. Social Security Number 215-18-1128 1□ M 2XF	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb. 99.	<b>*19</b> 02	9. Birthplace (Stata or Foreign Maryland	
	Maryland Fe show	Usual Residence of Dacedant  10a. Stata 10b. County  Maryland Frederick	10c. City, Town or Lo Frederick					10d. Insida City Limits 1 Yas 2 □ No	
	iter deeth with the Mar r terms 23s or 23s-f si ther must be notified Funeral Director	10e. Street and Number 315 West Seventh Stre	et	10f. Zip Code 2170	01	10	U.S.A.	hat Country?	
020			No No	Was Decedent of H If Yes, specify Cube 1☐ Yes 2☐ No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- Amarican Indian, s, Whita, atc. White	
Maryland 21215-0020	ed within 72 hours sygiene.  For then "natural", of it, for the older of the older of the older of the older of the older of the older of the older of the older of the older of the older of the older of the older of the older of the older of the older older of the older of the older older of the older old	15. Decedent's Education (Specify only highast grada complated)  Elementary/Secondary (0-12)  College (1-	(Give	dent's Usual Occup kind of work done DO NOT use retired Homemake	ing 1	Own Ho	usinass/Industry		
land	should be and Mentel marked o matic ev	17. Fathar's Nama (First, Middla, Last)	1	110mcmcmc	e (First, Middle, M	laiden Sumame			
Mary	2 should be and M is married in m	19a. Informant's Name/Ralationship (Type, Print)		ng Address (Street	and Number or Rura	al Route Number,	City or Town, 5	Stata, Zip Code)	
	1 and 1 Heelth em 27 other tra	Mr. David L. Buhrman, S  20a. Method of Disposition	on 315 on 315 on 315 on 20b. Place of Dispo	West Seve	nth St.,	Frederic	oc. Location - C	21701 City or Town, Stata	
Baltimore,	permit. Peges 1 and Department of Heelth Important: If Item 27 eny Injury or other to DRES.	1 N Burial 2 □ Cramation 3 □ Ramoval from S 4 □ Donation 5 □ Other (Specify)	cemetery, cre	matory or other plac	y, Nov. 8, 1			rick, Maryland	
Balt	Departi Departi Importi eny inj pnce.	21. Signature of Funaral Sarvice Licenses  Richard E. Dro	12	2. Nama and Addre Geney and	Bacford	P.A. Fu	neral H	ome	
		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one causeion as	used the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	ist,	Approximata Interval Between Onset and Death	
7	/Medical	Immediata Causa (Final disaasa or condition	neumni					16/7	
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68760,	ificate be executed g physician and as the bunal-transit edical Examir	Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events	Due to (or as a consec	wasse of	off:				
Box 68	E 0 6	rasulting in death) Last	Dua to (or as a consec	juence oi).					
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E E	Page Con					1 □ Ye	s 210No	1 Yas 2 No	
<b>X</b>	Physician: The this certificate ral director, page TO Be Co	25. Was case rafarrad to medical axaminar? Hospital:		Oth	26. Place of Death				
	th. After this continues of funeral direction: To	27. Mannar of Death 28a. Data of	patient 2 ER/Outpetier Injury , Day Year)  28b. Time o Injury	f 28c. Injur	4CL Nursing Ho	ma 5 Reside 28d. Describe ho			
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	within 2 To the comple	29b. Signatura and title of certifiar		29c. Licens	e number	29	d. Date signed	(Month, Day, Year)	
		· Custin Dear			9689		11/5	799	
		30. Nama and addrass of person who complated cause	of death (Item 23a) (Type,					01.701	
	0	Austin Pearre, Jr., M	0 300 West No	inth Stre	et, Frede	rick, Ma	ryland	21701	
	State Registrar	NOV 0.5 1000	we by	dan .					

DHMH 16 Rev 6/95



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					Cert	ificate	of Death		Reg. No. 9	9 3	36650	
n	1. Dece	dant's Name (First, Middle	le, Last)					2. Data of De Month	ath Day	Year	3. Time of Death	
Physician /Medical	EV	Ά		BC	LLINGE	R		OCTOBER			12:55PM	
Examiner	4a Faci	lity Nama (If not institution	n, giva street and numbe	r)			4b. City, Town, o	r Location of Death	4c. County	of Death		
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be notified	-	eet and Number	IETICK	TI	.iur mon c	10f. Zip C	oda		10a. Citizen of V	en of What Country?		
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10		Jacob Stite	1y				Mary	Elizabe	th Fresh	nman		
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	Ste	erling E. Bo	llinger, so		10 Li			mont, Ma	ryland	21788	3	
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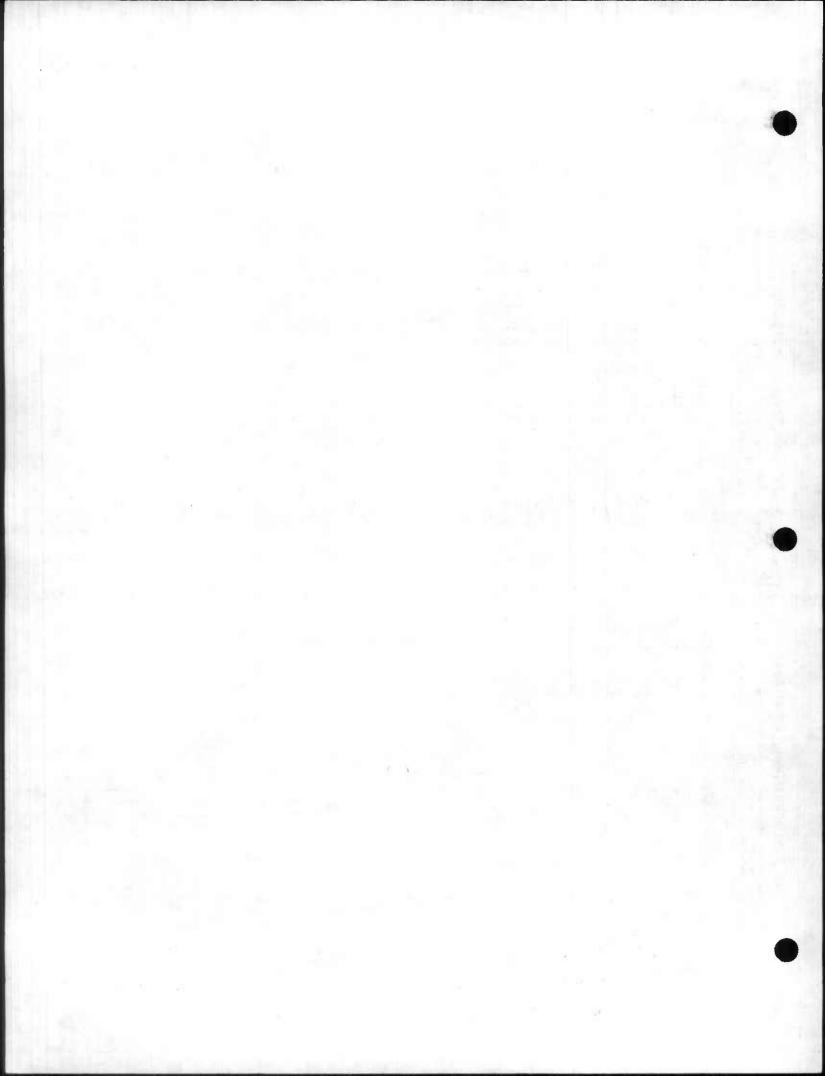
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month November 4, 1999 10:01 pm Elizabeth Brown /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner College View Center of Frederick Frederick Frederick If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) May 14,1910 If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 153-22-3922 89 Yrs. Ireland Director Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d Inside City Limits Walkersville Maryland Frederick 1X Yes 2□No Director 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be 21793 300 Chapel Court U.S.A. Funeral 11 Maritel Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0020 White 1 Yes 2 XNo Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in ment of Health and Mental H lant: If them 27 is marked off jury or other traumatic even Be Thomas Kiernan Margaret Sherwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5811 Corporal Jones Ct, Mt Airy, Maryland 21771 Mrs Joan Fader/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burlai 2 Cremation 3 Removal from State Department of Important: If any injury or Hollywood Memorial Park Nov 9, 1999Union, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home bersen M00706 106 E Church Street, Frederick, Maryland 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final PARVMUN14 disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner HITherner. The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or as a consequence of) Box 68760. Conjustice Heurt Physician/Medicai Due to (or as a consequence of) 980 igned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.0. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Atrail K.S. 1/4 (-) Records, py 24b. Were autopsy findings eveilable prior to Be Completed 24a. Was an autopsy director, page 2 should completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medicai 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Gerard A Del Grippo, Jr, MD, 15 East Frederick Street, Walkersville MD 21793 32. Registraria Signatura

State Registrar

31. Date filed (Month, Day, Year)

NOV 0 8 1999 >



State of Maryland / Department of Health and Mental Hygiene

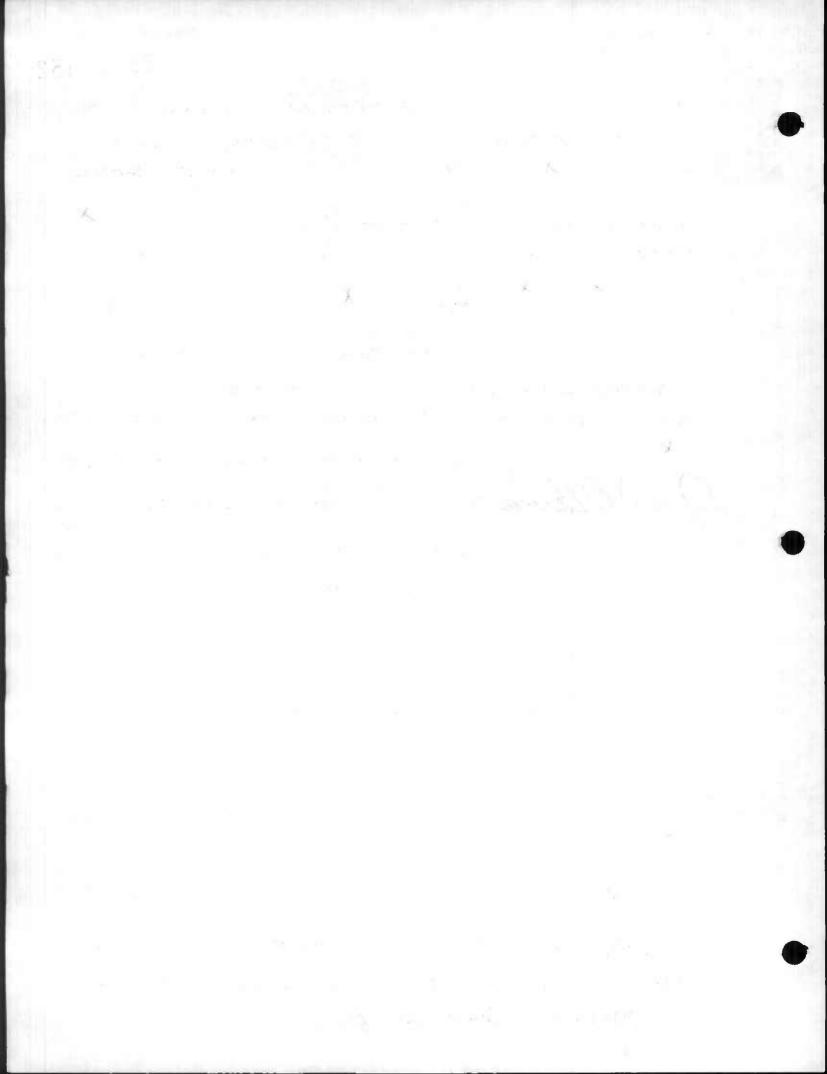
36452 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Nov. 1, **Physician** 1999 9:25 AM Douglas Bloodsworth, Sr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PO Box 103 30350 Oak Street Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 02/28/1925 Birthplece (State or Foreign Country)
 Maryland **Funeral** Months Devs Hours 74 Director 218-16-8547 Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Yes 2□No Funeral Director Maryland | Somerset Princess Anne 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 30350 Oak Street PO Box 103 21853 **USA** 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No WWII
If Yes, Give
Yeer or Detes: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Ovster Grower Seafood traumatic event. permit Pages 1 and 2 should be file.

Department of Heelth and Mental Hy, important; if Nem Z7 is marked other any Injury or other these. Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be L. Beauchamp Bloodsworth, Sr. Agnes Bozman 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 30350 Oak Street, PO Box 103, Princess Anne, Md. Barbara Bloodsworth/Wife 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Beechwood Cemetery 11/4/99 Princess Anne, Md. 22. Name and Address of Facility Hinman Funeral Home ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate ne cause on each line. Approximate Interval Between Onset and Death Physician mediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) attending ; Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown yd bengis À 2 24b. Were autopsy findings evailable prior to Completed 24s. Was an autopsy performed? completion of cause of death? certificate has 1 Yes 20 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 20 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Desidence 6 Dother (Specify) 94 27. Magner of Dea 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending investigation douth. 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28s. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled is Medical Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Saltry CONSTANTS Riverside 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar NOV 04



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Year Physician BALLARD DOROThy October 1999 09:05 PM. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 32443 Overholt Road Pocomoke City Samerset If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 214-30 - 7769 Usuel Residence of Decedant 1 M 201 F Yes Director 10b. County 10a Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Hem 27 le marked other than "naturel", or flems 23a or 28a-f ahor other treumatic event, the Medical Examiner must be notified at Pocomoke MD 1 Yes 2 No Director DOMERSET 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 32433 2185 verhoH Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Meritel Stetus hours after 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1☐ Yes 2M No Specify Specify. Black P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) illed within 7: Il Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Bus lerminAl Cook permit. Pagas 1 and 2 should be filed w Department of Haalh and Mentel Hygien Important: If Item 27 is marked other the any Injury or other treumatic event in-17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 89 Virginia UNKNOWN 0 ornist 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Roger ST. - Niect DALISBURY Jimmie . opes 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition Date cemetery, crematory or other place) 1 Buriel 2 □ Cremetion 3 □ Removel from State Church Cem. 13.M 11-2.99 rocomoke, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Anthony E. Ward +
30439 Hampdon Aw. 21. Signeture of Funerel Service Licensee Funeral Home 21853 Princess 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart tellural ist only one cause on each line. Approximate tnterval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in deeth) Lest and Due to (or es e consequence of): P.O. Box 68760. attending physician for use as the burie Physician/Medicai the Due to (or es e consequence of): USB BS Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? s been signed by the should be detach 4 Unknown 1 ☐ Yee 2 ☐ No 3 Probably Division of Vitai Records. by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy ate hes pege 2 s 2000 1 Tyes 1 Yes 2 No certificate - Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical etely filled in by the funeral director, Be 25. Wes case reterred to medical 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Home 5 \$\ \overline{\text{Residenca}} \ \text{Residenca} \ \ 6 \ \overline{\text{Other}} \ \( \text{Specify} \) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 XYas 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending invastigation Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined Location (Street end Number or Rurel Route Number, City or Town, State) Pleca of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours att To the Funeral Di completely filled In 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Ce 17 3 Medicai To the within 2 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 1999 30. Name and edgress of person who completed cause of death (Item 23a) (Type, Print) HON m 111 Penn Street, Baltimore, Maryland 21201 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signature State

Registrar

NOV 03 1999

greeki Lindon auto 185 that all our is a girl of the applications. the smaller that and and he are THE AND THE PROPERTY OF THE PARTY lease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Lines Certificate of Death 5. and 10c. SC WCHD 11-9-99 Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Nov.5, CURFMAN 1999 06:45 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home WASHINGTON Hagerstown If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 200 F <del>2189</del> 219-36-3906 Director 96 June 24,1903 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar maint be notified at 1 Yes 2 No Director Washington Williamsport Williamsport 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. d 2 should be filed within 72 hours after tith and Mental Hygiene. 27 ie marked other than "netural", or itse treumatic event, the Medical Examina 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: à Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Teacher Education Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 Ie marked oth any Injury or other treumatic ever Be Charles Lee Curfman Annie Ceclia McCardell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delancy Cattlett 144 N. Artizan St. Williamsport, MD 21795 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Riverview Cemetery Nov.9, 1999 Williamsport, MD 21795 22. Nama and Addrass of Facility OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between Onnet on Death Physician Klymorus /Medical Immediate Cause (Final diseasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): USB but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ CAndio Marcula 24b. Wara autopsy tindings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to make a examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Phath 1 Cheffural 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. Medical 29a. Certifier complately (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number 36655

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

NOV 0

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445/2/42

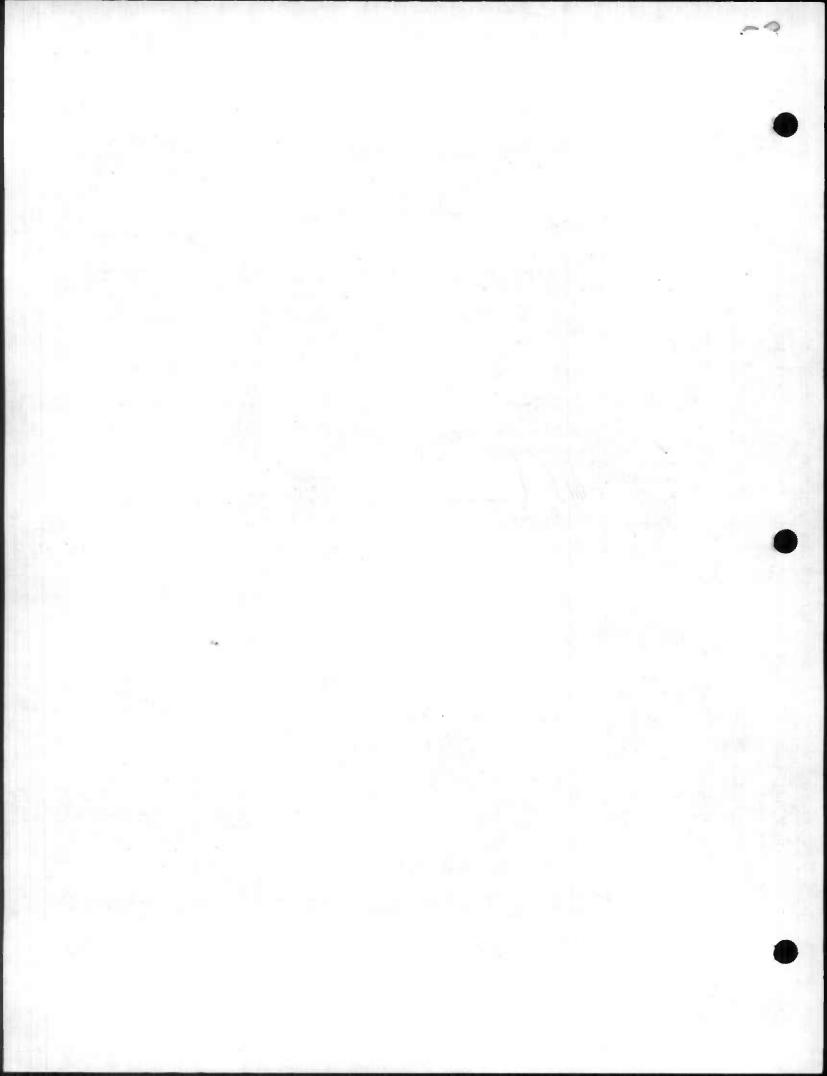
Rd. HAGERSTOWN MD 21740

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1999

9



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) **Physician** 10:30 AM October ana /Medical 4c. County of Death George's 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death Examiner Regional Hospita Laurel Laurel If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 25 F Months Yrs. 458-62-6952 **Director** Dec 26, 1914 Arkansas Usual Residence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ed other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at the Maryla 1 ☐ Yas 2 No Directo Prince George Laurel 10f. Zip Coda 10g. Citizan of What Country? 10e. Streel and Number 9592 Muirkirk Road #Tl 20708 U.S.A. Funeral 14. Race - Amarican Indian. 12. Was Dacedant Evar In U.S. Armad Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Biack, Whita, atc. 72 hours after 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 Yas 2 No Specify: by 3 ☐ Widowad 4 ☐ Divorcad White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry d 2 should be filed within 7, and Mental Hygiene.
7 is marked other than "ru Collega (1-4or 5+) 5+ Elementery/Secondary (0-12) Teacher Community College 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Patrick Henry Coy Susan Katherine Weaver 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 at Department of Health and Important. If Item 27 is an any injury or other traum 0005. 19a. Informant's Name/Ralationship (Type, Print) Ruth Coy /niece 9592 Muirkirk Road #Tl, Laurel, Maryland 20708 Baltimore, 20b. Place of Disposition (Name of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Othar (Specify) 10/22/99 Catonsville, Maryland 22. Nama and Addrass of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one ceuse on each line. 23a. Part1. Enlar lhe diséa shock, or haart failure Approximata Interval Batwean Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in deeth) Examiner a to (or as a consaquanca of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Box 68760. monary Physician/Medical that initiated avants rasulting in death) Last Dua to (or as a consequence of): ena 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? Completed cartificate has 2 No Physician: 25. Was casa rafarred to medical examiner? Be 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No To 2 ER/Outpatient 3 DOA this funaral 28d. Describe how injury occurred 27. Mennar of Death 28b. Tima of 28c. Injury at Work? Certification: Aftar 5 Pending investigation 1 Natural Attending 1 ☐ Yas 2 ☐ No death. 2 Accident or Attend after death Director: 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) à 4 Homicida 24 hours after Funeral Dire 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha cause(s) and menner as stated.

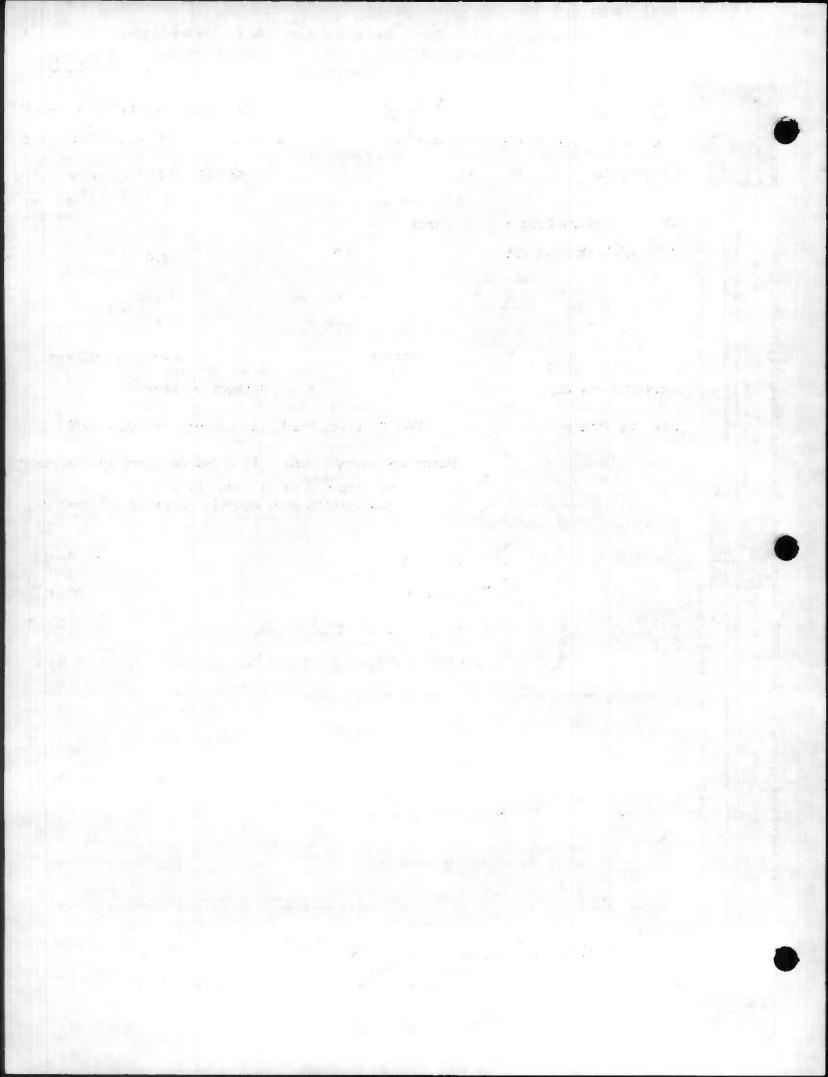
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29a. Cartifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Yaar) 29b. Signatyre and titla of cartifiar October 21, 1999 39. Nama and addrass of person who complated cause of daath (Itam 23a) (Type, Print) 12 Dr #102 Laurel MD Armstron Larrel 31. Data filed (Month, Day, Yaar)

Registrar

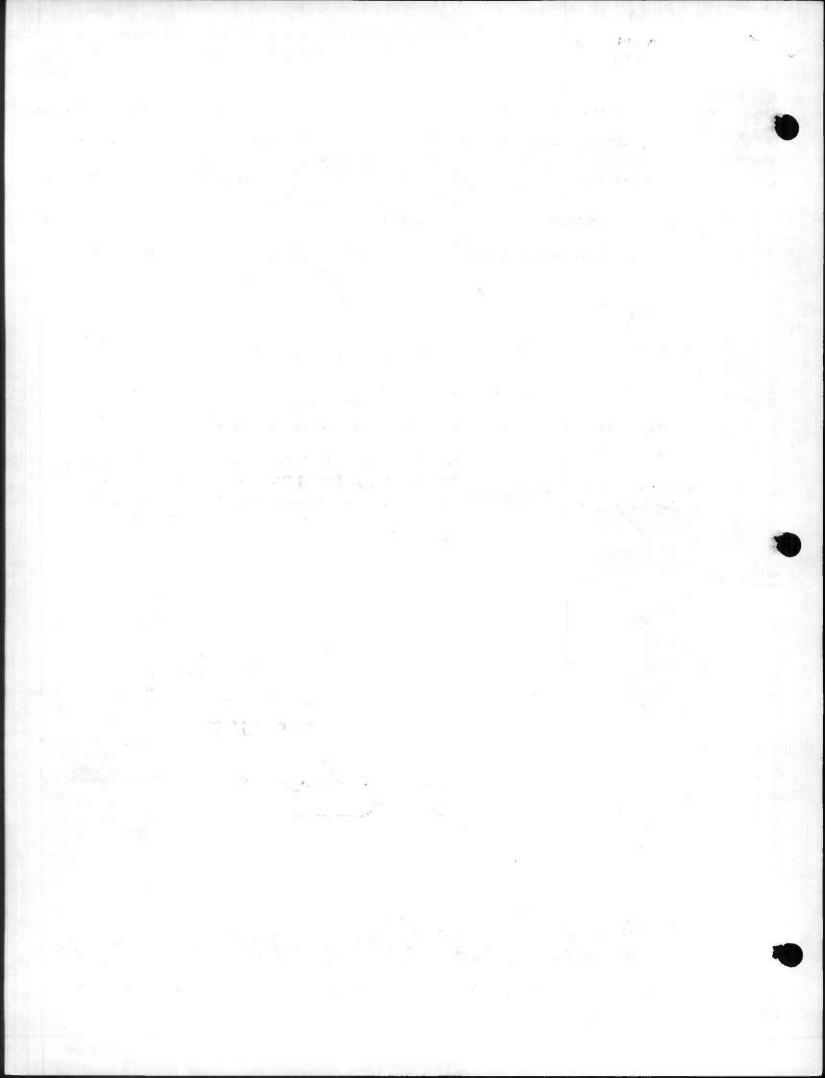
OCT 2 2 1999

32. Registrar's Signatura

B. Spark



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	Dharatal		1. Decedent'e Neme (First, Middle,					7	2. Dete d	of Deeth Qu	tobe	r 16,199	gf Death
4	Physici /Medi		Thomas Joseph (			11 33 4			Octo		199		p.m.
À	Examir		4a. Fecility Neme (If not institution,						vn, or Location of I	Deeth 4c	. County o	of Deeth	
	_		Shady Grove A		-	-	Millades 4 Vees		kville			gomery	
	Funeral Director		5. Social Security Number 024-30-1142	5. Sex 1 Ø M 2 □ F	7. Age (In yrs. 59	lest birthday) Yrs.	Months Days	If Under 2 Hours		h, Dey, Year)		<ol> <li>Birthplece (Stet Country)</li> <li>Iassachus</li> </ol>	
	pud *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Loc	cation					10d. Inside	City & imite
	Aaryle f sho	5		gomery	100.0	German							es 2 No
	the A	Director	10e. Street end Number	30mer y		OCTINATI	10f. Zip Code			10a Cit	tizen of W	het Country?	
	3a or		18806 Bent V	Willow Ci	rcle			2087	74			States	
	deeth	Funeral	11. Marital Status	12. Was Dece	dent Ever in U		Vas Decedent of h	lispenic Orig	in? (Specify Yes	or No-		- American Indien,	
Maryland 21215-0020	within 72 hours efter deeth with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	Armed Ford  1 Tyes 2  If Yes, Give  Yeer or De	2 D≸No ∋		Yes, specify Cube  ☐ Yes 2 1 No	en, Mexican, Specify:	, Puerto Rican, etc	:.)	Specify:	White, etc.	
2-0	2 ho	Completed	15. Decedent's	Education		16e. Deced	ent's Usuel Occup	ation		16b. K	ind of Bus	siness/Industry	
21	within 7 ene. than "r	npie	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	life. E	kind of work done OO NOT use retire	d) d)	or working	U.S	3. Go	vernemtn	
21		2		5 +		Direct	or of De				F D		
and	e d al b	Be	17. Father's Name (First, Middle, La			-			r's Name (First, M	iddle, Maiden			
Z	d 2 should be th end Mental 7 is merkad o traumatic eve	스	Thomas  19a. Informent's Neme/Relationship		allaha:				rtrude			ynch	
Ma	C1 - T =		Patricia E. Brin		ahter		g Address <i>(Str</i> eet Bugle Ct					stete, Zip Code)	
	Health Health tem 27		20a. Method of Disposition	ison / dat			sition (Neme of netory or other ple		Dete			City or Town, Stete	
OT.	Peges ent of t: If if		1 ■ Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spe				arys Col		10-22-	-99 Emn	nitsb	urg, Mar	vland
Baltimore,	permit. Peges 1 end Depertment of Health Important: If item 27 any injury or other tr once.		21. Signeture of Funerel Service Li		110		. Neme and Addre						_
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	_		23a. Part1. Epter the disease, or co	omplications that ca	used the deal						ICK,	Approxim	nete
3	Physician		Tendre. Est of	ny one cause on ee	or ime.							Onset en	d Death
	/Medical Examiner		Immediate Ceuse (Finel disease or condition	θ.	A	cute My	ocardial	Infa	rctions			Min	utes
	LXGIIIIICI	_	resulting in deeth)		Due to (	or as e conseq	uence of):					1	
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8760,	slcie e bur	dlcai	thet initieted events	C	Due to (c	or es e consequ	ience of).					1	
9	tificed g phy es th	0	resulting in deeth) Lest		200 10 (0	00 0 00115041	301100 01).					-	
Box	death certific e ettending p ed for use es	Physician/M		d								194	
	the ett	sici	Pert II. Other eignificant condition	e contributing to dea	ath but not res	sulting In the un	derlying cause giv	en in Pert I.	23b.	Did tobacco	use cont	tribute to the caus	e of death?
P.0	± 60 €									1 ☐ Yes 2	□ No	3 ☐ Probably 4	Unknown
Vital Records,	8 5 9	d by							240	Wes en euto	inev	24b. Were eutops	v findings
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Re	e lav has ge 2	Completed								4 T V 6		of deeth?	
ta	ician: Th certificete rector, pa		25. Was case referred to medical					36 Diago	of Deeth (Check of		L <sup>2</sup> No	1 □ Yes 2	□ No
<u> </u>	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1   In	patient 2	ER/Outpetien	3□ DOA Oth	AC:	rsing Home 5		6 ∏Othe	r (Specify)	
J Of	g Physical distribution		27. Manner of Deeth			28b. Time of	28c. Injur Wor			ribe how inju			
Sio	Attending r death.	atic	1 Naturel 5 Pending Investiga	tion	on M 1 ☐ Yes 2 ☐ No								
Division	al or Attendests efter destiling Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Locat City o	ion (Street er or Town, Stete	nd Numbe a)	r or Rurel Route N	umber,
	To the Hospital or Attending Phymin 24 hours eiter death. To the Funeral Director: Affer thi completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Phyeician: To the baseniner: On the baseniner	sis of examine	owledge, death etion end/or inv	occurred et the tir estigation, in my o	ne, dete end pinlon, deet	plece, end due to h occurred et the t	the cause(s	) and men d place, e	nner es steted. nd due to the ceus	B(S)
	To the within 2 To the comple	Ne S	29b. Signature and title of pertities		1	//	29c. Licens	e number		29d. Da	ite signed	(Month, Dey, Yeer	)
3			1/1/	n /	Uls	- My	W) 1	73	3261	0	of	16.19	99
			30. Neme end eddress of person with	no completed cause	of deeth (Iter	n 23e) <b>(</b> Type, I	Print		, , , ,		- [	1	
			William	Dooley,	MD /	9901	Medical	Center	Dr./ Ro	ckvill	Le, M	D 20850	
	Sta		31. Dete filed (Month, Day, Year)	V	gistrar's Signa		da-	1					
	Registr	ar	OCT 2 0	1004	Lys		· jagoon	was					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Year Physician 31, 1999 Ann Cassis October 7:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Homewood Nursing Retirement Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 1□ M 2 F Hours Months Days Yrs 89 Director 578-07-9179 1909 South Carolina Dec. 13, Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Maryle nant of Health and Mental Hyglene.
Instit if Nem 27 le marked other than "natural", or frams 23a or 28a-f show that if Nem 27 le marked other than "natural", or frams 12a or 28a-f show tay or other theumatic event, the statical forming in mail be notified as 1 Yas 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 West Patrick Street 21701 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Married Specify: White Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Yaar or Datas: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 self homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 8 Joseph Seller Mary Ellen Hardee 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 11449 Alton Road, Frederick, MD 21701 Steve H. Cassis, son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nama of cematery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: if any injury or page. 11/1/99 Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility Keeney and Basford Funeral Home MOO999 106 East Church Street, Frederick, MD

23a Fartt. Entir the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or boart failure. List only one cause on each line. 21701 Approximata Interval Between Onset and Death Physician Immediata Cause (Final /Medical disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown Vone Š 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? s certificata has b director, pege 2 a 1 ☐ Yas 2 ☐ No Division of Vitai or Attending Physician: director. 8 25. Was case referred to medical 26. Place of Death (Check only ona) 1□ Yes 20 No Other: Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending invastigation After death. 1 Yes 2 No To the Hospital or Attendition 24 hours effer death.
To the Funeral Director: A completely filled in by the fo 2 Accident NA 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statad.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Colenadantto MI V) 30020 99 30. Name and address of person who completed causa of death (ftem 23a) (Type, Print) Shutta, MD, PO Box 310, Walkersville, Maryland

**DHMH 16 Rev 6/95** 

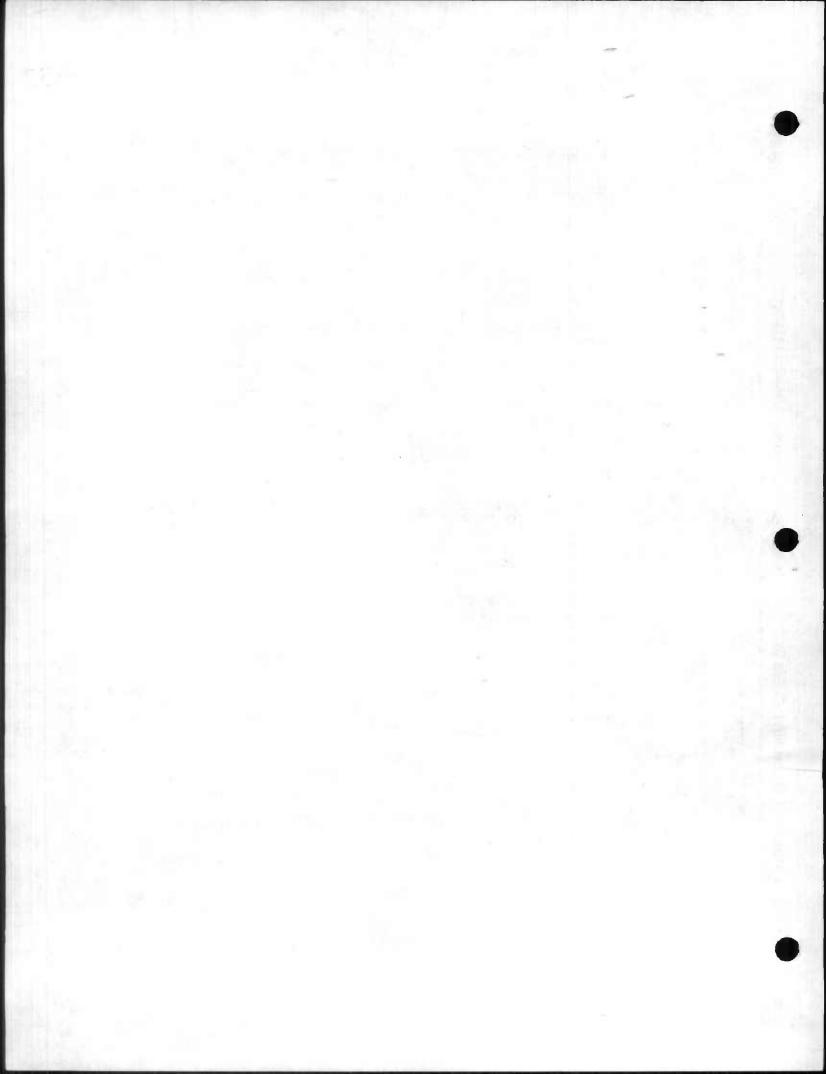
State

Registrar

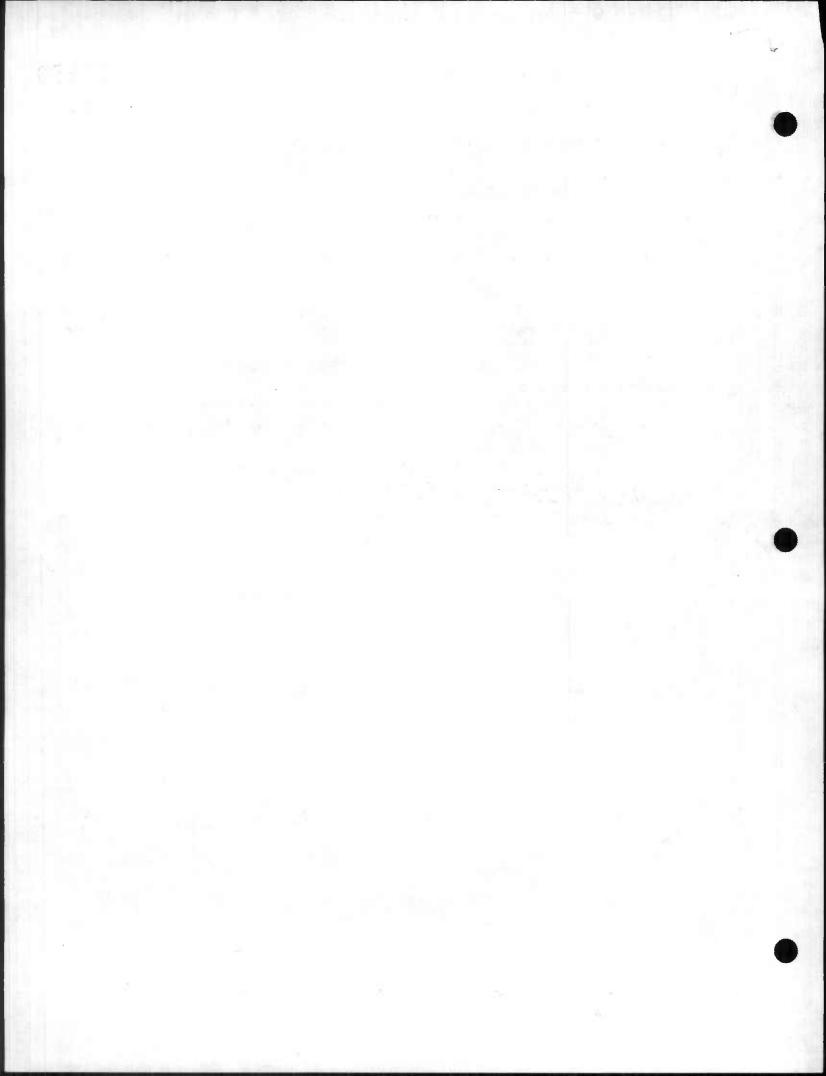
31. Date filed (Month, Day, Year)

NOV 02 199

32. Registrar's Signatura



	1. Decedent's Nam		11/3/99 , Last)	rend	K5	ertificate			2. Data of De			3. Tima of Death		
an al	CATHERINE MARIETTA CARLISLE						Month Octobe	er 30,	1999	7:17 AM				
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ctor	5. Social Security N 214-10-1		6. Sax 1 ☐ M 2 🛣	and the state of t				8. Data of Bir (Month, Di June 2	Birth Day, Year)  9. Birthplace (Steta or Foraig Country)  1909 Maryland					
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	21. Signature of Fundament Address of Fecility ROBERT E. DAILEY &						EY &	SON FUNERAL HOMES, P.A. ST., FREDERICK, MD 21701						
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Death October 29, 1999 Mildred Lydia Crawford 7:30 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Shady Grove Nursing Center Rockville Montgomery H Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplece (Stere Months Deys Hours Min. June 22, 1914 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1□ M 2□F Yrs. 215-62-6322 85 Usual Residence of Deceden 10b. Count 10c. City, Town or Location t0d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 5685 Mountville Road 21710 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Stetus Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas YNO If Yes, Give Year or Detes: 1 Yes XX No Specify: Specify: White XX Widowed 4 □ Divorced Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Plunkert Mamie Elizabeth Cutsail Felix Lorenzo 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 14514 Banquo Terrace, Silver Spring, Md. 20906 Mrs. Linda L. Davis, daughter 20b. Ptece of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery, Nov. 1, 1999 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Nama and Address of Fecility. Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximeta Intervel Between Onsat and Daeth Immediete Cause (Finel disease or condition resulting in death) kew week, ongestive Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Wara autopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Cardiac Dysrhythmia 2 7 No 1 Yes 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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After t Attending

n 24 hours after death.

The Funeral Director: After the following the f

To the Hosp within 24 hou To the Fune completely fi

Hospital or

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The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If New 27 is marked other any Injury or other traumatic avent, pages.

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

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Rema 23a

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72 hours after

Baltimore, Maryland 21215-0020

the Madical Examiner must be notified at

Director

Funeral

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Completed

Physician/Medical Examiner þ Completed Be Medical Certification: To

25. Wes case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 28d. Dascribe how injury occurred

27. Manner of Death 1 Neturel 2 Accident 3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be detarmined

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier G-Gupta, mp 29c. License number 46398 29d. Date signed (Month, Dey, Year)

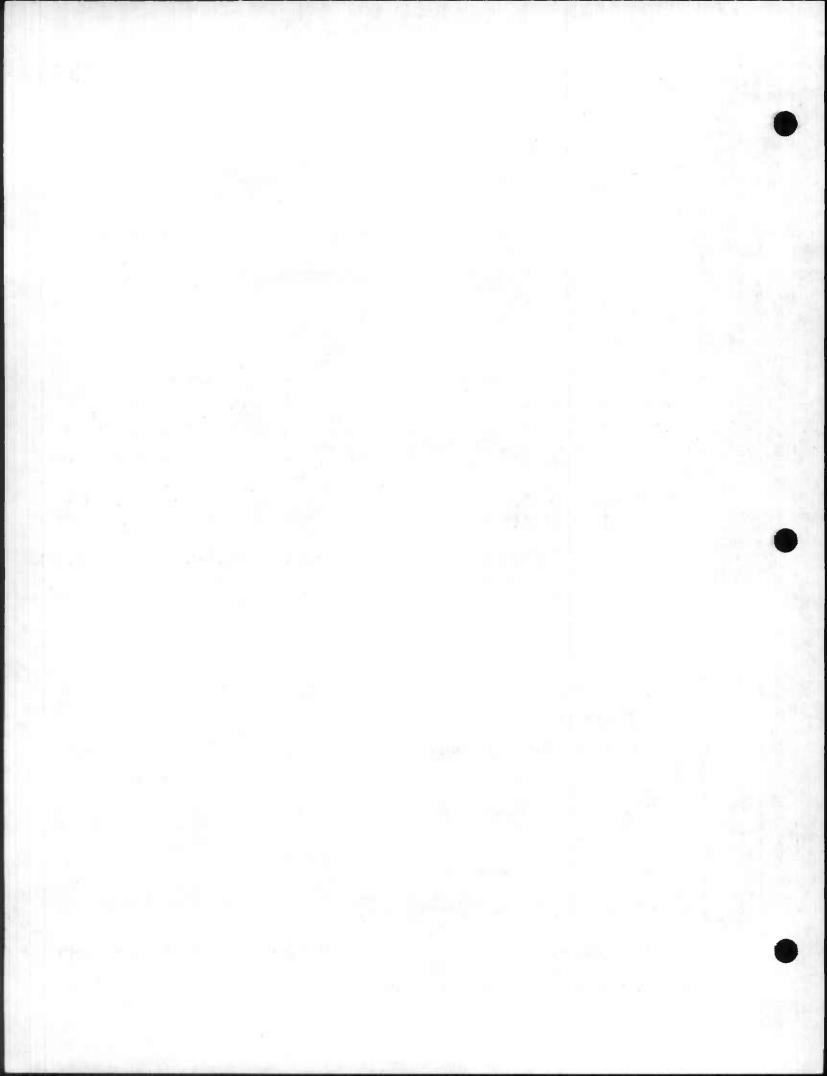
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

121 congressional #409 Lane

Rockvilk, Mp 20852

State Registrar

32. Registra s Signature 0 3 1999



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** November 2, 1999 0015 cation of Death 4c. Counity of Death WEST CORNINE /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER Cornine SS#218-16-67 Maryland 21215-0020 SALISBURY WICOMICO If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 21 F Months 218-16-6747 Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Peges 1 and 2 should be filed within 72 hours after death with the Merylan neart of Heelih and Menial Hygiens. In that them 27 is marked other than "natural", or theme 23a or 28a-f ahow ary or other traumatic event, the tend 10d. Inside City Limits Maryland Wicomico 1 Yes 2 No Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 104 Hillside Dr. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Merital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2€ No Specify: Specify: p 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Salesperson Retail Sales 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) James R. West. Ethel Lee Parsons 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance R. Cornine/Son 1207 Pennypacker Lane, Bowie, MD 20716 permit. Peges 1 end Department of Heelth Important: if Item 27 any Injury or other ti phos. 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Greenation 3 Removel from State 4 Donation 5 Other (Specify) 11/6/99 Salisbury, MD Parsons Cemetery 22 Name and Address of Fecility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licer 501 Snow Hill Rd., Salisbury, MD 21804 234 Pluf1. Enter the disease, or complications that caused the hunck, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth with. Do not enter the mode of dying, such as cardiac or respiratory errest **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a cons equence of) Pa Physician/Medical Examiner physicien and s the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 68760. Due to (or es e consequence of): Box ( 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 3 Probably 4 Unknown 1 Yes 2 No Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 12 Inpatient edical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division After 1 Neturel 2 Accident 5 Pending after death. Director: Aft d in by the fur 1 Yes 2 No investigetion 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D completely filled 1) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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Registrar

30. Name and address of person

31. Date filed (Month, Day, Year) NOV 0 4 1999

Deepak

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E. RIVERSIDE DI.

ted cause of death (Item 23a) (Type, Print)

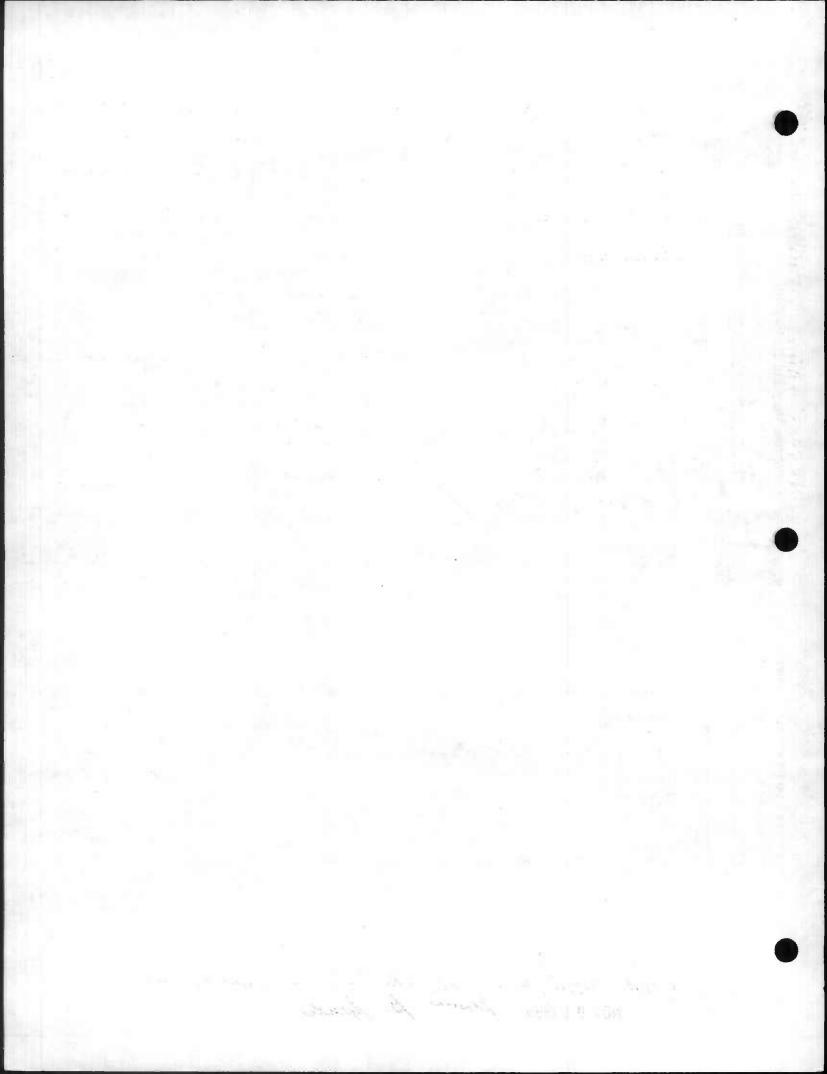
32. Registrar's Signature

M.D.

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salisbury, mo



State of Maryland / Department of Health and Mental Hygiene

	Otto	o or maryland	Certificate of	Death	Reg. No.	99 361.61				
Dhysisian	Decedant's Nama (First, Middle, Last)		ta of Death onth Day	Year Year						
Physician /Medical	DONALD BRYAN CROCKETT				tober 29	1999 0600				
Examiner	4a Facility Nama (If not institution, give street and PENINSULA REGIONAL MI	4b. City, Town, or Location SALISBURY	,							
Funeral Director	5. Social Security Number 6. Sex 220–32–9467	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	Hours Min. (M	te of Birth onth, Day, Year) Ly 16,1931	9. Birthplace (State or Foreign Country) Maryland				
Jend Jend	10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits				
deeth with the Meryland ms 23s or 28s-f show trinset be notified at neral Director	Maryland Wicomico	Fri	uitland		1 反 Yes					
vith the Me to 28a-f s be notified Director	10e. Street and Number		10g. Citizen of What Country?							
h wit	416 W. Main St.	.6	USA							
	11. Marital Status  1 Nevar Married 2 Married  1 X Married 1 X Mar	Decedent Ever in U.S. of Forces? Navy (res 2 No Kore	- de la companya della companya della companya de la companya dell	Hispanic Origin? (Specify Yo ban, Mexican, Puerto Rican, Specify:		Race - American Indian, Black, White, etc.				
15-002 72 hours natural', pilcal Exp		or Datas:	So Deceded Head Occ		10h Kind	of Business/Industry				
2 jag 1	15. Decedant's Education (Specify only highest grade comple Elementery/Secondary (0-12) Colle	ted) ge (1-4or 5+)	6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin							
and 212. be filed within tiel Hygiena. d other than avent, the M	17. Fathar's Nema (First, Middle, Last)		Route Salesm	18. Mother's Name (First		ing co.				
Maryland d 2 should be file the and Mental Hy T is marked othe traumatic avent.	W. Bryan Crockett			Madeline	Pusey					
Maryla d 2 should th end Men 7 is marke traumatic	19a. Informant's Name/Ralationship (Type, Print)		19b. Mailing Address (Stree	nt and Number or Rural Rout	-	own, State, Zip Code)				
Ma 20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Mary Louise Crockett/			in St., Fruit						
ore, Maryland 2:  jes 1 end 2 should be filed w of Heelih end Mentel hygie of Heelih end Mentel hygie filem 27 is marked other up other traumatic avent, the	20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other plants	Dat		ion - City or Town, Stata				
Pages nent of liny or or	1 Surial 2 Cramation 3 Removal f	rom Stata	inghill Memory C		199 Hebr	con. MD				
Baltimore, permit. Pages 1 er Depertment of Heel Important: If Item 2 any Injury or other once.	21. Sunatura of Funeral Service Licenses   22. Name and Address of Facility   Followay Funeral Home Professional Association									
	79 M. atello	way	501 Snow	w Hill Rd., Salisbury, MD 21804						
100	23a Page. Entar tha disaasa, or complications to antick, or heart failura. List only ona cause	hat caused the death. I on each line	To not enter the mode of dy	ing, such as cardiac or resp	iratory arrest,	Approximata Interval Between Onset and Death				
Physician /Medical	Immediata Causa (Final	4 /				0.000				
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O. Box le deeth cer the attendir hed for use	Part II. Other significant conditions contributing	iven in Part I. 2	23b. Did tobacco use contribute to the cause of death?							
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A Records, The law requires to take has been signe, pege 2 should be.	afral byll	Nin	,	2	4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause				
Rec e law has b					V	of death?				
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f Vital   yalclan: The yalclan: The director, peg	25. Wes case rafarred to medical examinar?			26. Place of Death (Che	ck only one)					
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Div Div To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b	29a. Certifiar (Check only  1 Certifying Physician: To 2 Medical Examiner: On ti	ne basis of axamination								
thin 2 the bomplet	one) and	manner stated.		se number		igned (Month, Day, Year)				
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1/1/	MI		9-	2/14/	10/2	1/57				
12	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
State Registrar	31. Data filed (Month, Day, Year) NOV 0 1 1999	2. Regisfrar's Signature	B. Ana	KI						

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

6 Could not be determined

3 ☐ Suicide

29a. Cartifiar (Check only one) 29b. Signature and titl

4 Homicide

	Ple	ase Type or	Print in	n Black I	ndelible	e ink	. Assur	re A	III Copie	s Are	Legi	ible.	Q.	
				and / Dep		t of H	Health ar		Mental Hy		0. ,	261	1.00	
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		on, give street end nu GIONAL MED	ICAL C				SAL	LISI	BURY			y of Death		
5. Sociel Security N 219-07-7	024	6. Sex 1 🛣 M 2 🗆 F	7. Age (In y	III yrs. and Dirtifoldy/			If Under 24 Hours	Min.	U. DOIG OI DI	Day, Year)	916	9. Birthplace Country) MARYLA	(Stete or Foreign	
Usuel Residence of 10e. Stete	10b. County	у	10c.	. City, Town or	Location								nside City Limits	
MARYLAND	WORC	CESTER		BERLIN									Yes 2X No	
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11. Maritel Stetus	DAN	12 Was Dac	cedent Ever in	n U.S. 1	3. Wes Deced	dent of H	Hispanic Origin	in? (S	specify Yes or N		14. Rac	ce - American to	idien.	
1 Never Mem		Armed Fo	orces? 2 🔯 No Siva		If Yes, speci	cify Cuba	an, Mexican, I	Puerto	o Rican, etc.)					
-	city only highe	nt's Education est grade completed)	)	(Gin	icedent's Usual ive kind of work b. DO NOT us	rk done o	during most o	of wor	rking	16b. Kir	nd of B	Business/Industry	,	
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21. Signeture of Fu	peral Service	Licensee - Wate	-		22. Neme end			1				, DE. 1		
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281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Mospital or Attending Physician: The lew requires that the death certificate be executed within 24 bours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

**Physician** /Medical

Examiner

12

State Registrar

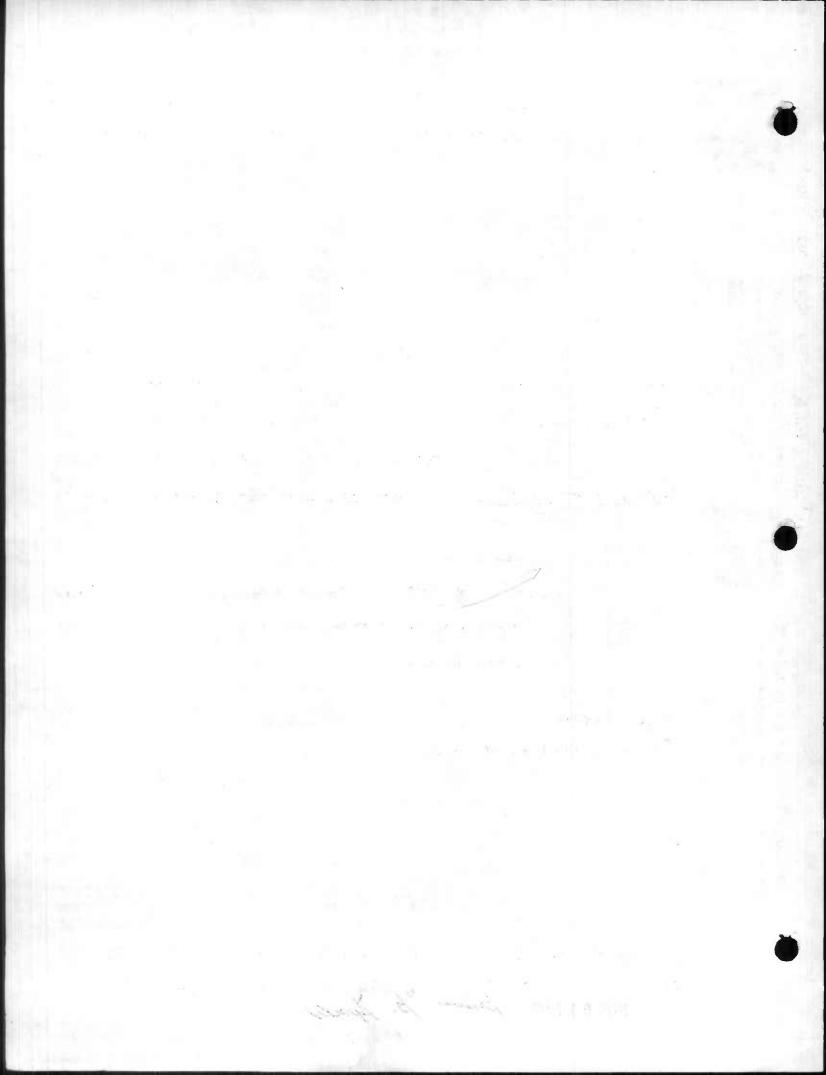
D0053551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrer's Signature 25, Sal, 36 pry 19d 21801 Dr. James Todd Bluff

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

THE CERTIFYING Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steled.

29c. License number

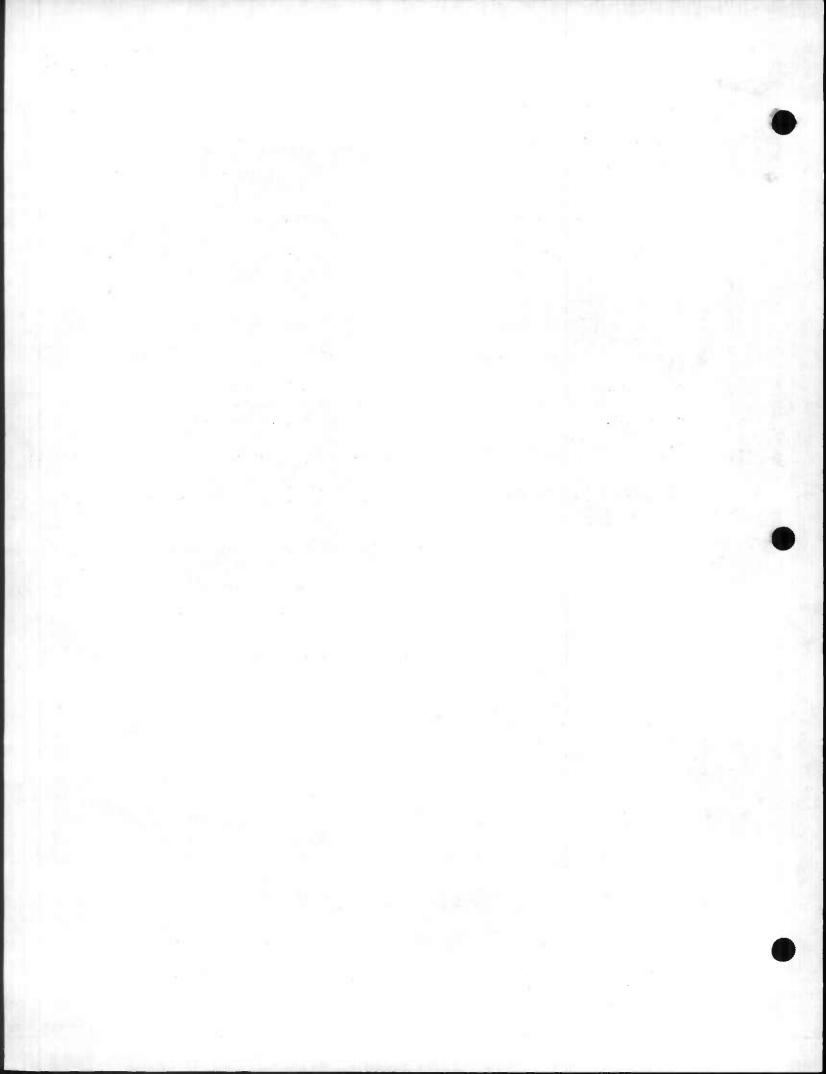
28e. Pteca of tnjury - At home, farm, street, fectory, office building, etc. (Specify)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

36463 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Date of Death October **Physician** GEORGE WILLIAM DRAPER /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Oct. 7, 191 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1₩ 2□ F Months 82 Yrs. 214-09-7376 1917 Director Maryland Usuel Residence of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location ral", or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1138 Cottage Court 21740 USA daath Funerai 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after dital Hygiana.
diother than "natural", or itemevent, un Medical Examination Black, White, etc. 1 ☐ Yes 2 X No If Yes, Giva Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Engineer Aircraft Manufacturer 12 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Pagas 1 and 2 should be nant of Health and Mantal Jesse Wolford Draper Mary Kitzmiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5 Department of Health ar Important: If Item 27 is any Injury or other trau Hilda Iona Draper, Wife 1138 Cottage Court, Hagerstown, Maryland 21740 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery Nov. 1 Hagerstown, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility
Douglas A. Fiery Funeral Home unmerman 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heak failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Cardiskes /Medical Immediate Cause (Final Louis disease or condition resulting in death) Examiner Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No Vital 25. Was casa referred to medical examiner? Be 26. Placa of Death (Check only ona) 1☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury al Work? Medical Certification: 1 Natural 5 Panding investigation death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be detarmined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Hospital or 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner statad. 29a. Certifier To the Hose within 24 ho To the Fune completely fi 29b. Signature and title of continer 29d. Date signed (Month, Dey, Year) 29c. License number Mill St. Hagerstown MD, 2174 30. Name and address of person who complated Jausa of daath (Itam 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State NOV 01 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36464 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death **Physician** Month Cloe Estella Dietrich 11:55 pm October 27 1999 /Medical 4a. Fecility Neme (If not institution, give street end number, 4b City, Town, or Location of Death 4c. County of Deeth Examiner Colton Villa Nursing Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 5. Social Sacurity Number 8. Date of Birth (Month, Dey, Yeer) Jan 21, 1917 7. Age (In yrs. lest birthday) Birthplece (Stete or Foraign Country) Funeral 1□M XXF Days Hours Min 82 Yrs. Director Pennsylvania 188-10-0563 filed within 72 hours after death with the Maryland 10e State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner right be notified at 10d. Inside City Limits Director 1 ☐ Yes 2(No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 13604 Greencastle Pike 21740 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Й No If Yas, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American Indien, Bleck, Whita, etc. 1 ☐ Nevar Married 2XXMarried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Spacify only highest grede complated) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry alth and Mentel Hygiene. 27 is marked other than "r r traumatic event, he Med Elementary/Secondary (0-12) College (1-4or 5+) 12 Teller Bank 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mentel Irvin Huston Miller Florence Jeanetta Bishop 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is m eny injury or other traum once. Jesse Dietrich Husband 13604 Greencastle Pike Hagerstown, Maryland 21740 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State XXXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spacify) Rest Haven Cemetery 10-30-99 Hagerstown, Maryland 21. Signature of Funeral Service Licenses Osborne Funeral Home.P.A. 425 S. Conococheague St. Williamsport, MD 21795

Approximate a complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiretory errest,

Approximate Approximata Intervel Between Onsat and Deeth **Physician** RENAL FAILURG /Medical Immediate Ceuse (Finel 3 years disease or condition resulting in deeth) Examiner Physician/Medical Examiner PIABETES MALLITUS 104 eeus or Attanding Physician: The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that hitleted events resulting in death) Lest of Vital Records, P.O. Box 68760, Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Pert I. 23b. Did tobacco use contributa to the cause of death? ate has been signed by page 2 should be detec 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings aveilable prior to complation of cause of deeth? Be Completed 24e. Was en eutopsy performed? After this certificate 1 ☐ Yas A No 25. Wes case referred to medicel 28. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1□ Yes 25 No Other: Nursing Home 5 - Residence 6 Other (Specify) 2 filled in by the funeral 27. Menner of Deatl Dete of tnjury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation Naturel s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end ptece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29e. Certifier (Check only

State Registrar

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

MAN 2AR. J SIANFI 368 VI ICLS STREET HACIERS TOWN VID 21740

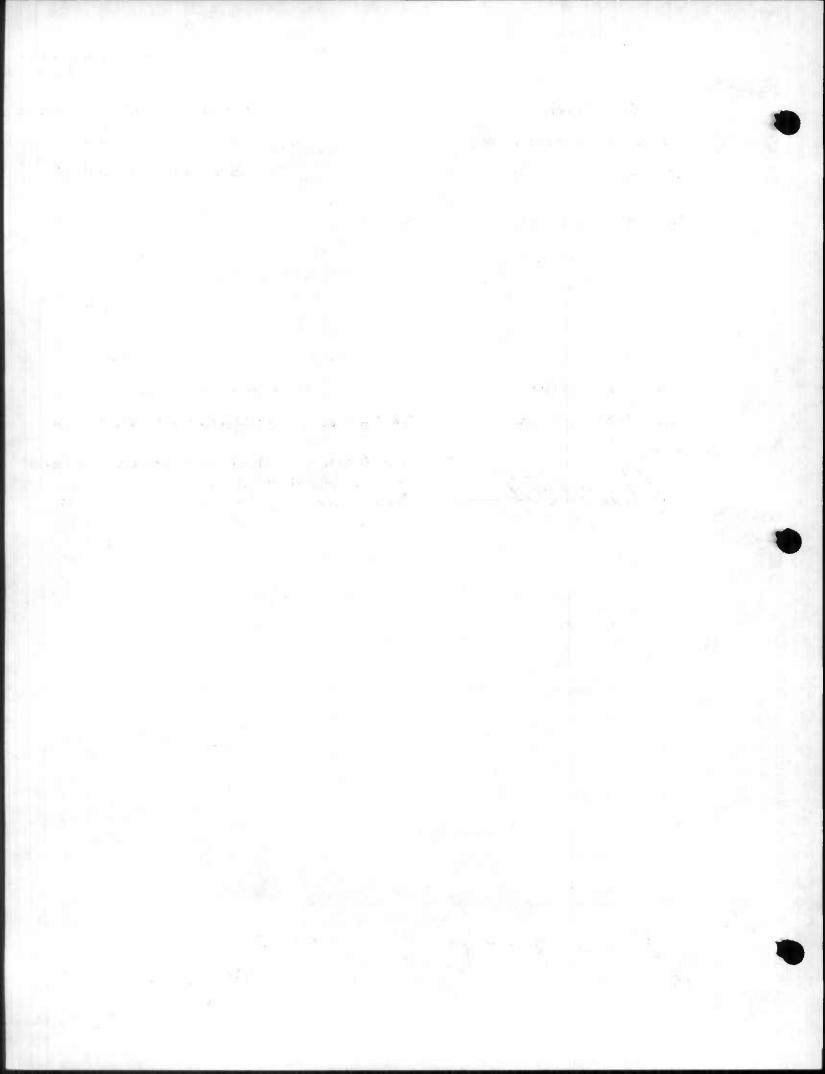
29b. Signature end titla of certifier

29c. License number

D28365

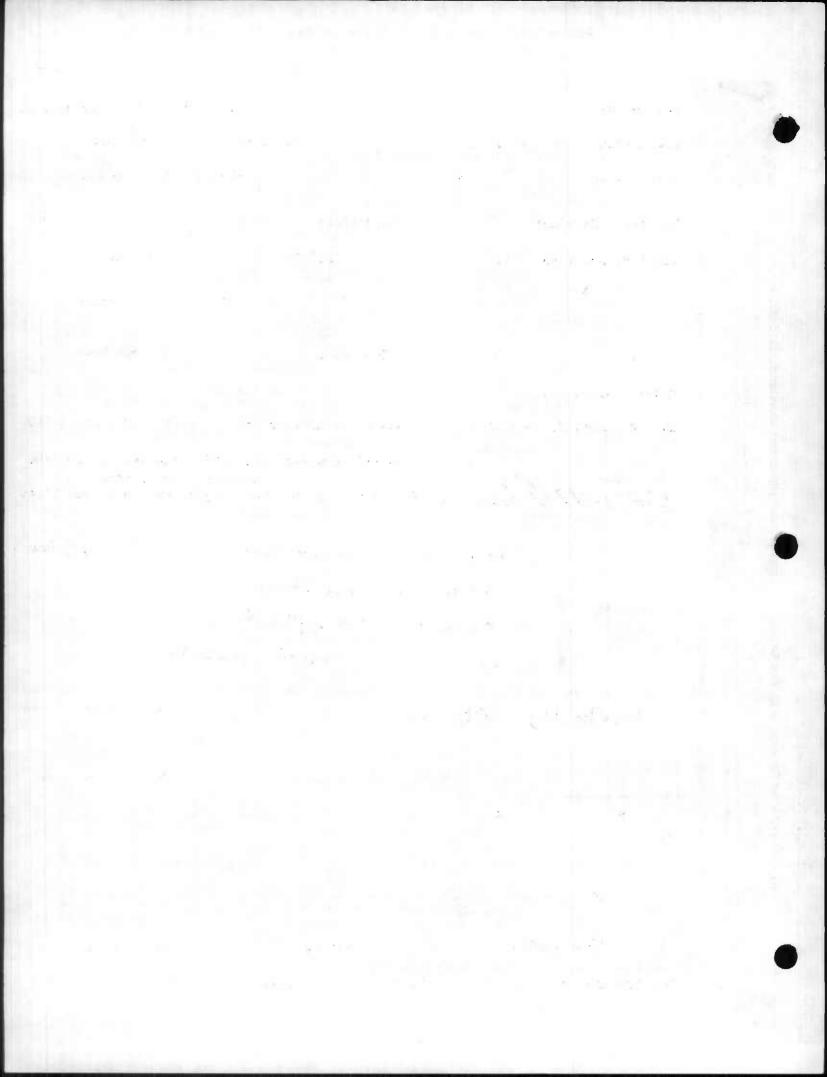
29d. Date signed (Month, Day, Year)

Division



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 1999 Nov. 12:21 p.m. Sue Ann DENEEN /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Yrs. Director 217-86-1066 Maryland 36 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
Int: if Itam 27 is marked other than "natural; or items 23s or 28s-f show ary or other traumatic event, its Medical Evantmer must be notified as 10d. inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Hagerstown Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 Funeral 12001 S. Scottish Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Her own home 12 0 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Stella Mason Robert Mumma, Jr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Hagerstown, Md. 21740 17336 W. Washington Street Robert Mumma, Jr. - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition permit. Peges Depertment of Important: If It any Injury or o 1 XBurial 2 Cremation 3 Removal from Stete 11/6/99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 21. Signature of Funeral Service License 22. Name and Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 nime 23a. Part1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset end Death **Physician** 48 Hours /Medical Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting in deeth) Examine Due to (or es e consequence of): Examiner physician end s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): attending pl for use as t Stage Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed is certificete has director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 28e. Dete of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation death ector 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Direc 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 11-1-99 D53548 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Mohammed Monzur, 12931 Oak Hill Ave., Hagerstown, Md. 21742 32. Registrer's Signature 31. Date filed (Month, Day, Year) State NOV 0 3 1999 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 31, 1999 Dorothy Manon DARR 2:45 p.m. /Medical 4b, City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Coffman Nursing Home Hagerstown Washington If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🖾 F 89 214-09-5778 Dec. 3, 1909 Director Maryland Usuel Residence of Decedent with the Merylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show TX Yes 2 No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? ò 11 W. Baltimore Street Apt. 716 21740 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Herrs 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify white by 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elamentery/Secondary (0-12) laborer aircraft Important: If item 27 is marked other any injury or other treumstic event. If 17. Fether's Neme (First Middle Last) 18 Mother's Name (First Middle Meiden Sumeme) Peges 1 end 2 should be nent of Health end Mental Martin Luther Drenner Anna E. Bowers 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Joy Heil - sister 10914 Lincoln Avenue Hagerstown, Maryland 21740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete Department 4 ☐ Donetion 5 ☐ Other (Specify) 11-3-99 Hagerstown, Maryland Rest Haven Cemetery 21. Signeture of Fameral Service Licenses MINNICH FUNERAL HOME 22. Name and Address of Fecility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the diseese, or complications that caused the shock, or haart failure. List only one cause on sech lina. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervet Between Inset end Deatl Physician Moet /Medical Immediate Cause (Final diseasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Division of Vital Records. 24b. Ware eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 100 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case rafagred to medicat examiner? 26. Place of Death (Check only ona) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred 28c. injury at Work? 1 Naturet 5 Pending 1 Yes 2 No deeth. investigation 2 Accident 24 hours after deel Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner steted. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and fittle of certifier 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN, MD 1185

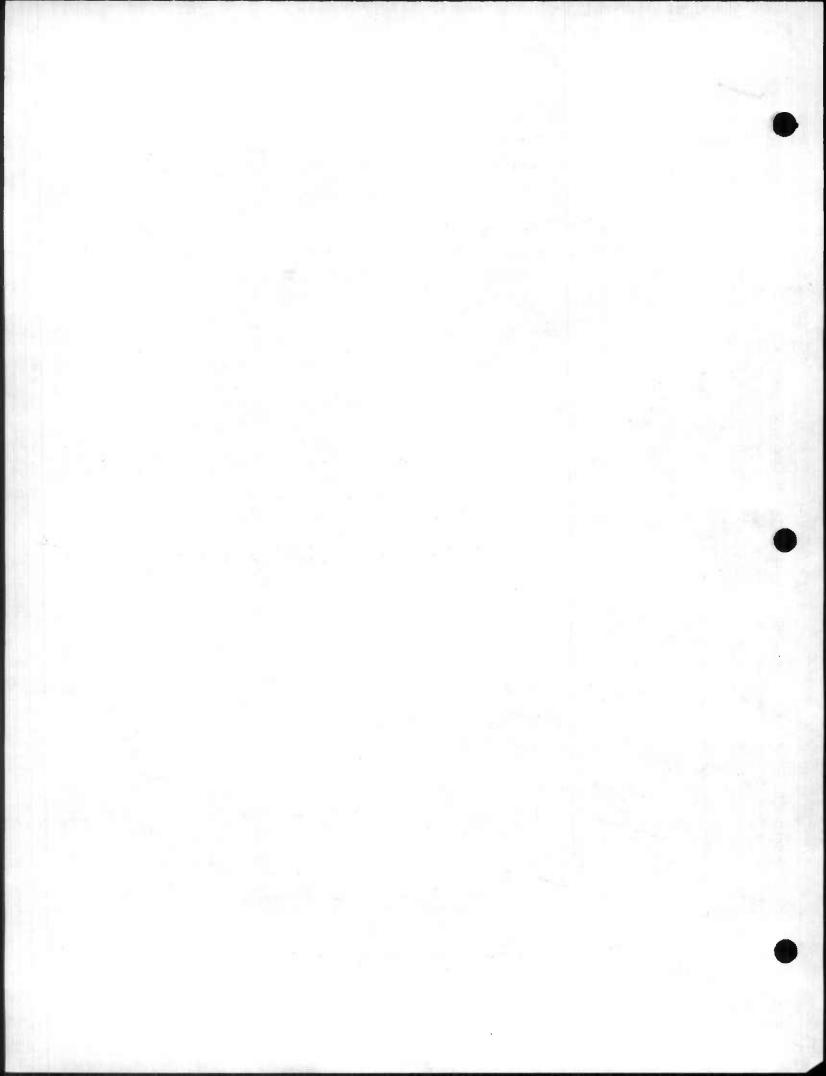
Registrar **DHMH 16 Rev 6/95** 

State

13Umns 31. Date filed (Month, Day,

MANON

32. Registrer's Signature

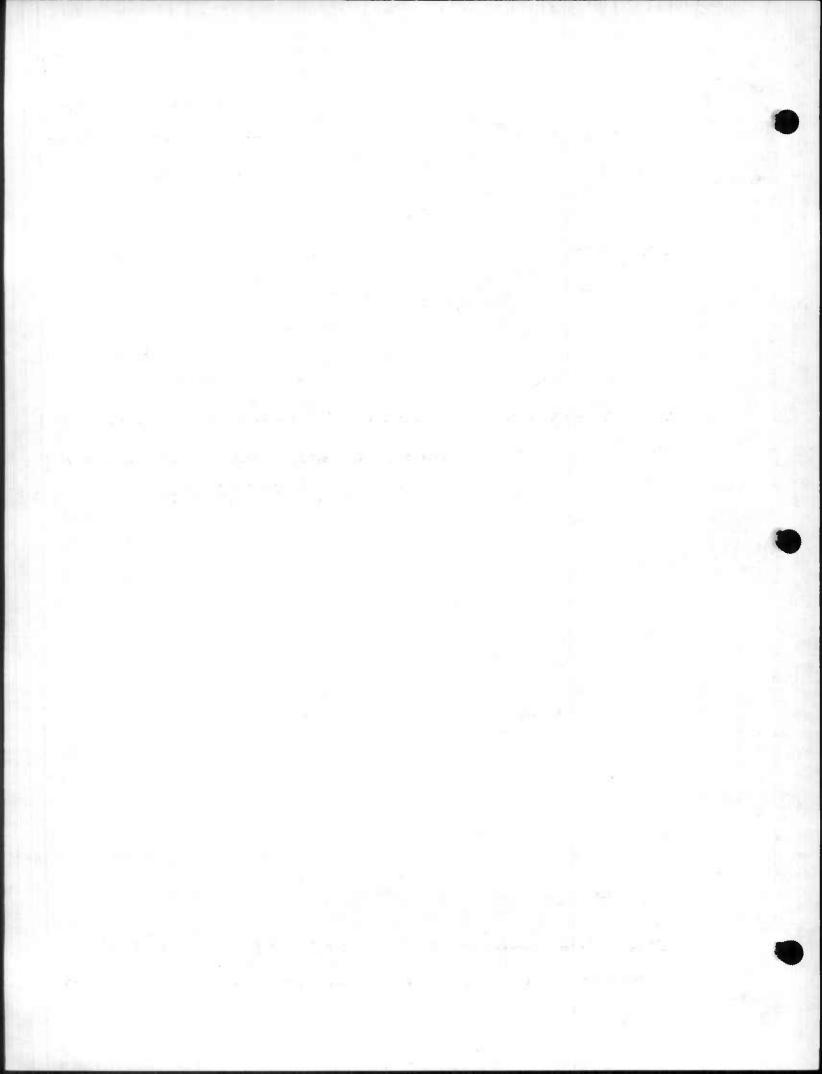


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month David Robert Durst Nov. 09 1999 1:35 a.m. /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Colton Villa Nursing Center Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 3, 19 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Deys 1X M 2□ F 79 Yrs. 213-16-9404 Director Ohio Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show soical Examiner must be notified at 10d. Inside City Limits Maryland Washington Co. Hagerstown Director 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 11233 Lakeside Drive 21740 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces?

1 M Yes 2 D No If Yes, Give Yeer or Detes: 11/18/45 Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) 12 Electronics Company .. Pages 1 end 2 should be filed w tment of Health end Mantal Hygier tant: If Item 27 Is marked other th jury or other traumatic event, the President Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be David Anthony Durst Ruth Marie Edwards 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Vivian Durst/Wife 11233 Lakeside Drive, Hagerstown, Maryland 21740 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or Smithsburg Crematory 4 ☐ Donetion 5 ☐ Other (Specify) Nov.9 Smithsburg, Maryland 22. Name end Address of Fecility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742 21. Signature of Funeral Servica Licansee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximele Onset end Deeth Physician /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) **Examiner** Physician/Medical Examiner The lew requires that the death certificate be executed the burief-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest P.O. Box 68760, Due to (or es e consequence of): for use as erebrisagular acid Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No of Vital Records, by ed bluods 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? director, page 2 2 400 this cartificate 1 ☐ Yes 2 ☐ NO Attending Physician: 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 40 Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division After 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No deeth. 2 Accident or Attend after deeth Director: In by the 6 Could not be 3 Sulcide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Destifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) address of person who completed clause of death (Item 23e) (Type, Print) coepects 32. Registrer's Signature 31. Dete filed (Month) State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death De Physician Month November 9, Barbara June Deason 1999 0400 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 228 Summit Avenue Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Days 1 □ M 2 X F Months 66 February 14, 1933 Director Oklahoma 444-30-8754 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show 1X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 228 Summit Avenue 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Raca - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 XNo Specify: p 3 NWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: If Itam 27 Ia marked other than "I any Injury or other traumatic avant, the Max Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Be Victor Chester Dake Georgia Irene Hail 0 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Tapp Hagerstown, Maryland 21741 47 E. North Ave., Apt. 3 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 11/9/99 Hagerstown Crematory Hagerstown, Maryland 21/Signature of Funeral Service Licen 22. Name and Address of Fecility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final Cerebral vascular accident unnediate disease or condition resulting in death) Examiner Examiner hupertension Sequentially fist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown asthma p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

attending physician and for use as the burial-transit Box 68760. certificate be P.O. the signed by i Records, peen has certificate Division of Vital funeral director, this After To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After 3

the Maryland

death

72 hours after

Baltimore, Maryland 21215-0020

29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. (Gheck only one)

29b. Signature and title of certific

29c. License number D0043389 29d. Date signed (Month, Day, Year)

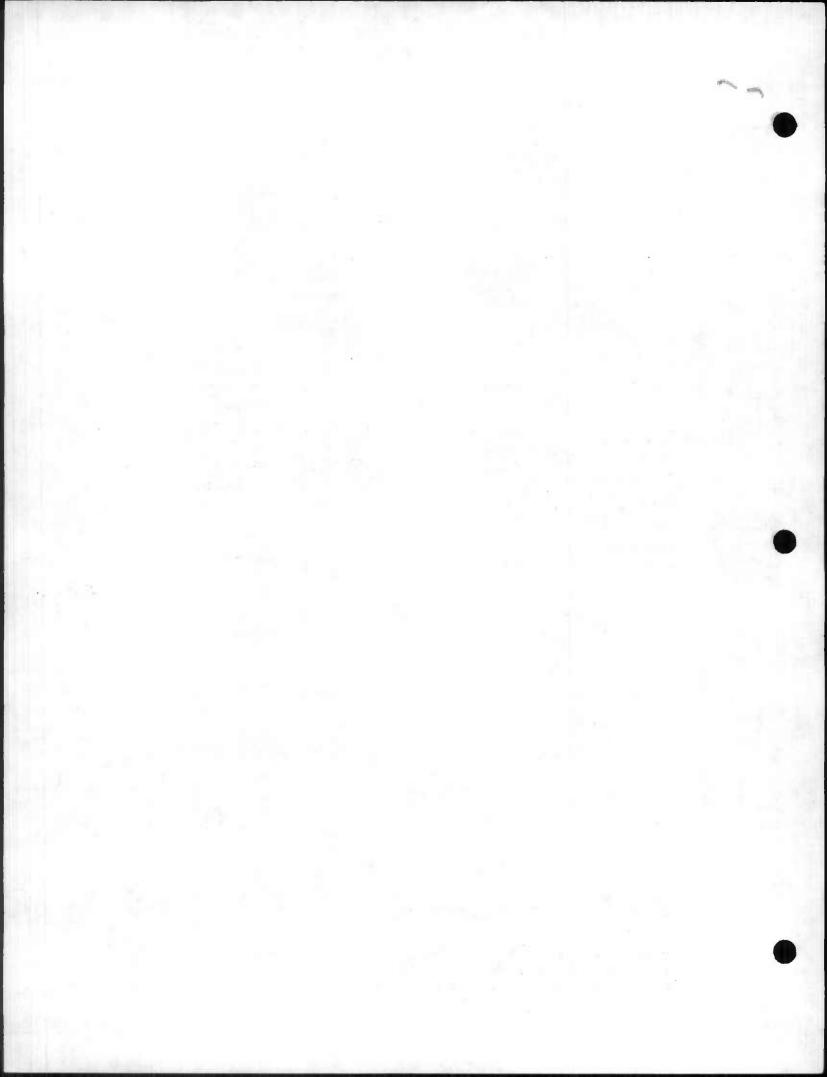
30. Name and address of person who come cause of death (Item 23a) (Type, Print)

Dr Susan Brinkley 11110 Hedical CAMAS ROSUINE 226 HAGERSTONN MO 21742 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

completely

edical



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State of Maryland /

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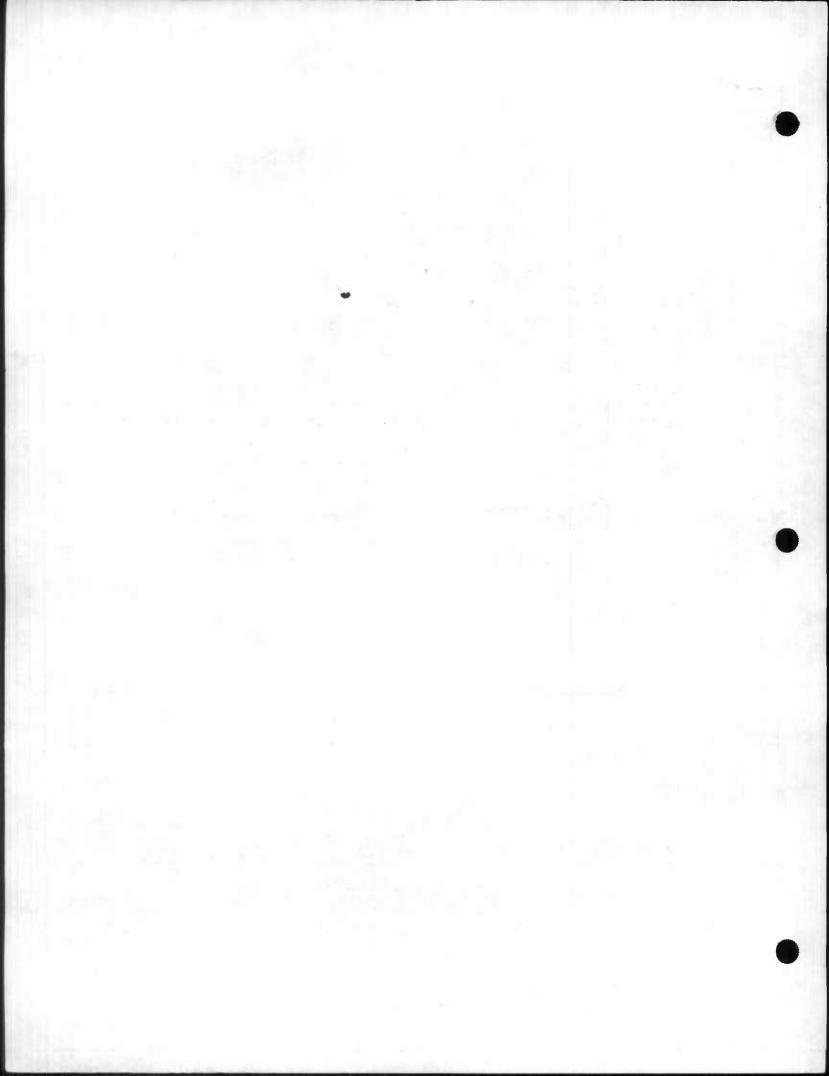
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Baltimore, Maryland 21215-0020	parmit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Danarhmant of Health and Maryla Landons	Important: If item 27 is marked other than "natural", or items 23s or 28s-f show
	Phy /M Exa	sic led ami
	Bcuted	pue

DEBORAH L. DRECHSLER Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Deborah Lynn Drechsler 24, 1999 OCT. 0630 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL ANNE ARUNDEL GLEN BURNIE | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | March 28, 1951 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Fuperal** 1□M 2QF Maryland 213-54-9077 48 ctor Usual Rasidance of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits Md. Anne Arundel No 2 No Severn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7810 Walnut Tree Road 21144 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 22240 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12)
Grade 12 College (1-4or 5+) Auto Parts Store Parts Manager 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) James Lonaberger Helen Fertenbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Drechsler/Spouse 7810 Walnut Tree Road Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. 28 1 ☐ Burial 2 Coremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 1999 Catonsville, Md. 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21 Signature of Funeral Service Licensee and a 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death ian Immediate Cause (Final diseasa or condition rasulting in death) ical nei Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): physicien es the burial-Box 68760 Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ò 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Yes 2□ No Vital I or Attending Physician: after deeth. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 0 MYas 2□ No Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury et Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No anverwholost control + hit tree withou 10-24-99 034 2. Accidant Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in 24 hou. 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Rt. 3 N/B near Mcknew Rd, Crofton Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E 25, 1999 OCT. 12 30. Nama and ad led cause of death (Item 23a) (Type, Print) Jestuner 111 Penn Street, Baltimore, Maryland 21201 0500 31. Date filed month, Day, Yes 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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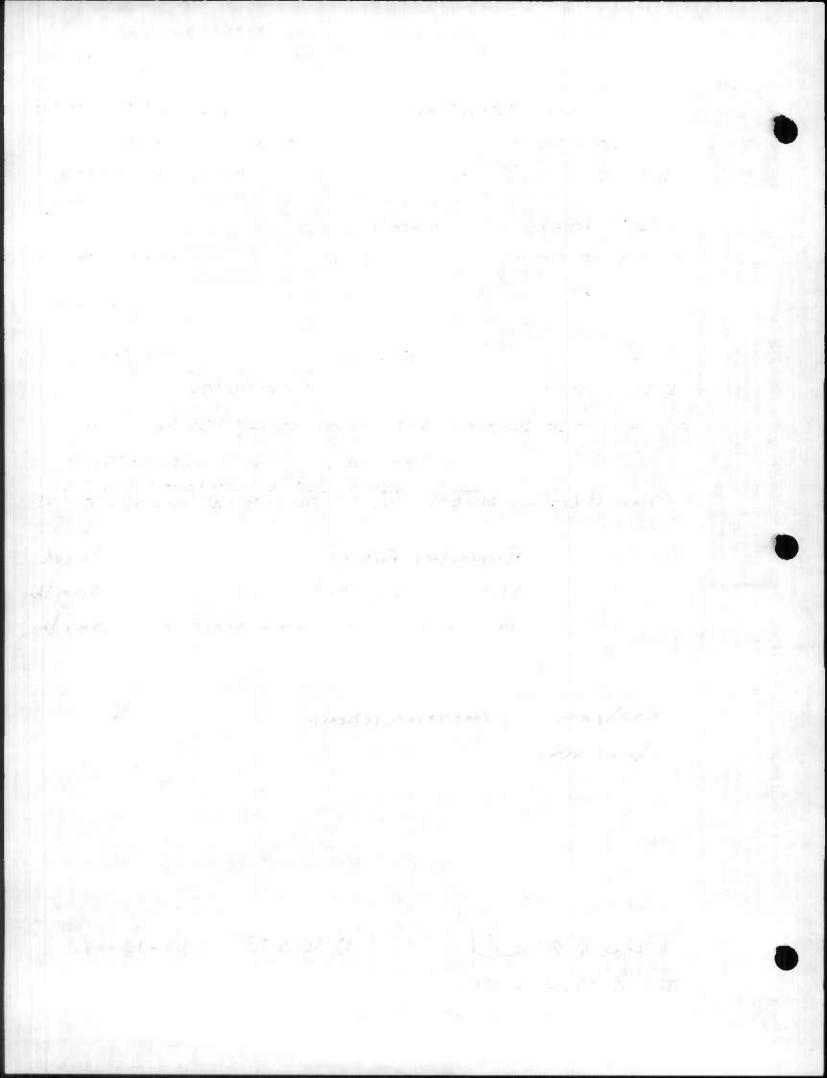
# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth **Physician** Barbara Shriver Devereux October 15 1999 11:55pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5701 B Harpers Farm Road Columbia Howard If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplece (Stata or Foraign Country) **Funeral** 1□M 2⊠F Months Days Hours Min Yrs. 75 Director 219-20-9703 May 31, 1924 Maryland Usuel Rasidance of Decedant the Marylend 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Departmant of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified. 1 Yes 2 No Directo Maryland Howard Columbia 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21044 United States 5701 B Harpers Farm Road Funeral Was Decadant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, 12. Was Dacedant Evar in U,S. Armed Forces? Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Dacedent's Usuei Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) (Give kind of work dona during most of working life. DO NOT usa retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Nama (First, Middla, Maiden Surname) 17. Fether's Nama (First, Middla, Last) William H. Shriver Hannah McCormick 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Neme/Relationship (Type, Print) 5701 B Harpers Farm Road Columbia, MD 21044 John Ryan Devereux III/Spouse 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 Buriai 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 10-19-99 Clarksville, MD Louis Cemetery 22. Nama and Addrass of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensae -a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immediata Causa (Final Resporatory Failure disaasa or conditior rasulting in daath) Examiner Examiner Multiforal Lung physician end the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Pancrea Cancer - neuro endocrine Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 52 USB ò signed by the a d be detached f Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobecco use contribute to the cause of deeth? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Anorexia - Cachexia. ģ 24b. Ware eutopsy findings evailable prior to completion of cause of daeth? 24a. Was an autopsy Completed ronsi anguiga hes page 2 1 ☐ Yas 2 ☐ No 1 Yas 2 No diractor. 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Chack only ona) To Hospitel: 1 ☐ Inpetiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 ☐ Yes 2 ☑ No this funerel 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mennar of Death 28c. Injury at Work? 28b. Time of Certification: Aftar or Attending 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death.

Funeral Director: A invastigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) filled in by 4 Homicida 29a. Certifian 🖎 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the causa(s) and manner es steted Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Exeminer: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number D 30 573 3 30. Nema end addrass of person who complated causa of death (Item 23e) (Type, Print) , MO. Minterd 31. Data filad (Month, Day, Yaa?) 32. Registrar's Signatura State OCT 1 8 1999 Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36471 Certificate of Death Amended line 10afchd, id 1. Decedent's Nema (First, Middle, Last) 3. Tima of Deeth 2. Data of Death **Physician** 1999 12:30 AM Josephine Darby October /Medical 4b. City, Town, or Location of Death 4e Fecility Nama (If not institution, give street and number) 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foraign Country) **Funeral** 1 M 2 XF Months 97 Yrs. 218-30-2513 Sept. 20, 1902 Maryland Director Usuel Residenca of Decedent 10a Stete 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumetic event, the Medical Examinar must be notified at 1 XYes 2 □ No Directo Maryalnd Frederick Frederick 94 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 305 E. Third Street 21701 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Bleck, White, etc. 72 hours after 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ğ 3 ☑ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural any lejury or other traumalic event, the Medical ORS. 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) self homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Nama (First, Middla, Last) Isabell Dodge William Noble Darby 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Darby, son 305 E, Third Street, Frederick, Maryland 21701 20b. Plece of Disposition (Nama of cemetery, crematory or other plece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Buriel 2 🏋 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 10/28/99 Smithsburg, Maryland Smithsburg Crematory 21. Signeture of Funeral Sarvice Licenses 22. Nama and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Ave., Cumberland, Maryland 21502 Mol 23a. Part1. Enter the disease, or complications thet caused the daath. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical morth Examiner Due to (or es e consequence of) Examiner ettending physician and for use es the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performad? Completed peen s has 1 Yes 2. No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician:
24 hours efter death.
 Funeral Director: After this certificaletaly filled in by the funeral director, I Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not ba 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 - Homleide 29a. Certitier edicai 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end mannar stated. (Check only

State Registrar

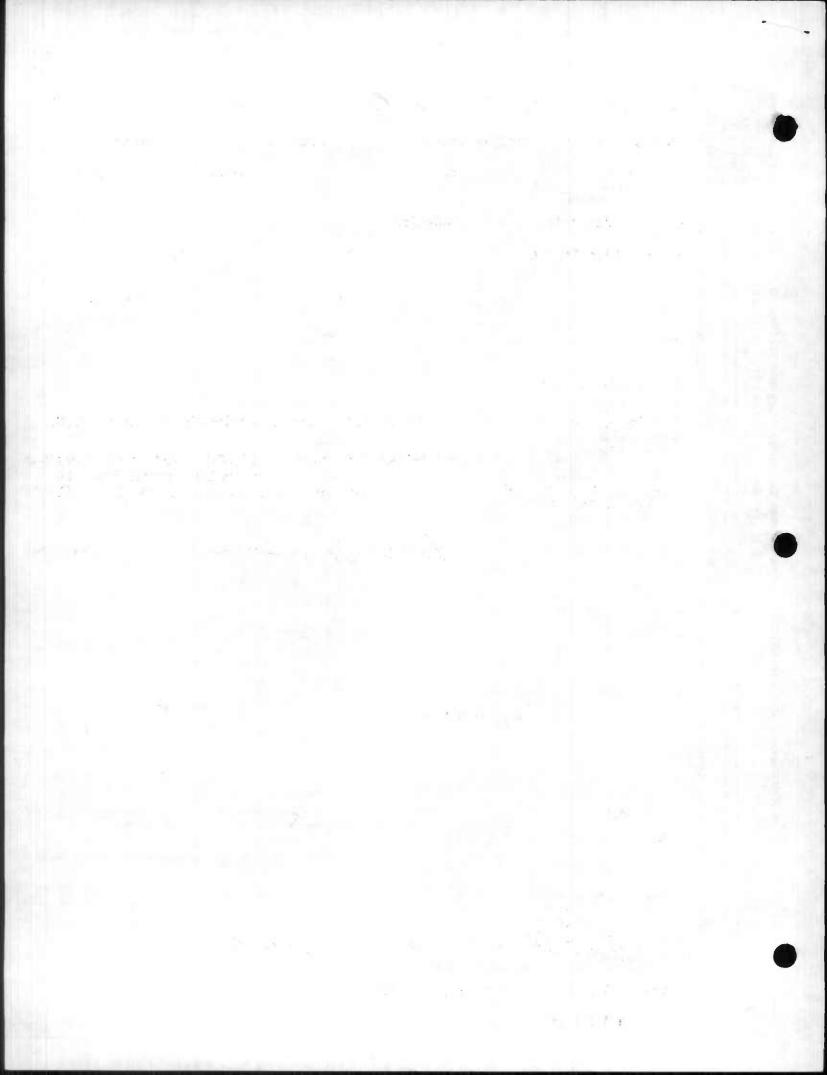
29b. Signature and title of

Ronald Miller, MD, PO Box 210, 31. Dete filed (Month, Day, Year) 32. Begistrer's Sign Mt. Airy, MD 21771

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

29d. Date signed (Month, Day, Year)

within 2



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

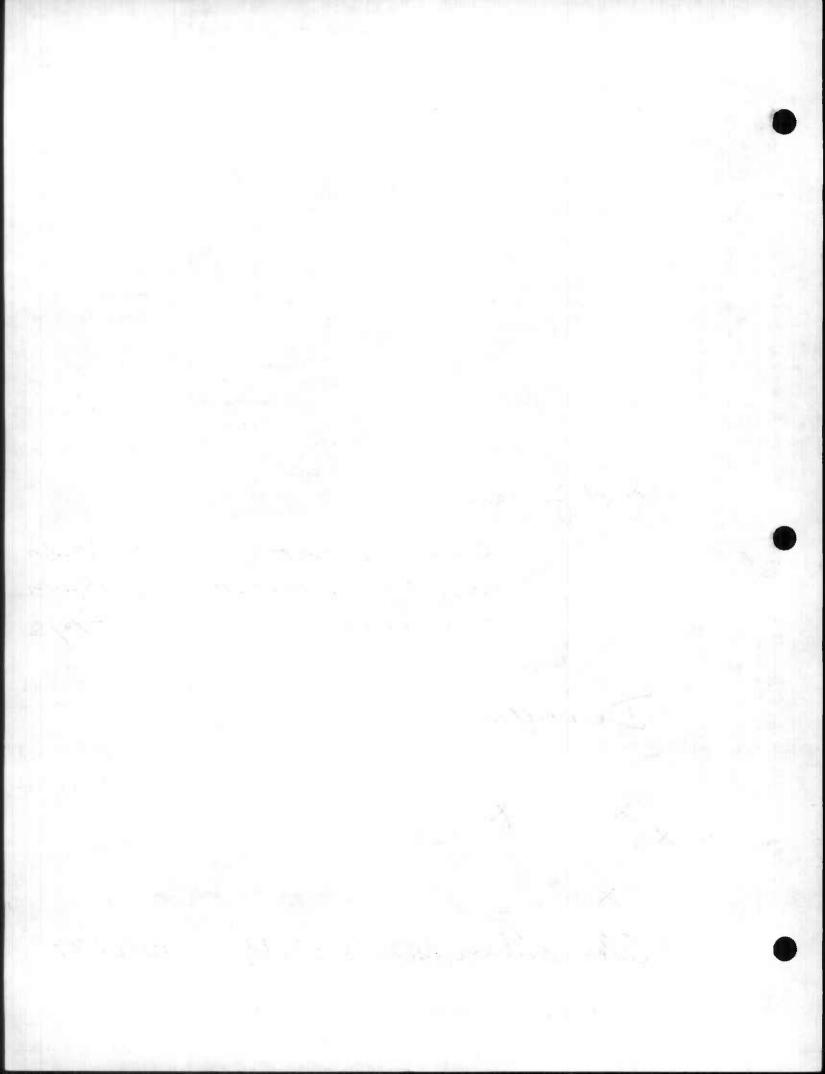
State of Maryland / Department of Health and Mental Hygiene 99

36472 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Physician CHARLES FRANK **OCTOBER** 27, 1999 4:10 AM DICKENS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) April 2, 1913 5. Social Security Number Birthplace (State or Foreign Country)
 New York 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours M 2□F Yrs. 072-09-0745 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Frederick MD New Market 1 No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21774 137 W. Main St Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1942-45 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Etementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed with Department of Health and Mental Hygient Important: if Item 27 Is merked other that any Injury or other traumatic avent, That once. Title Insurance Officer 8 Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Charles Dickens Mary MacArthur 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Anne Dickens / wife 137 W. Main St, PO Box 266, New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/28/99 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens Crematory Frederick, MD 22. Name and Address of Facility J.N. Zumbrun F.H. 21. Signature of Funeral Service Licensee 6028 Sykesville Rd, Eldersburg, MD 21784 mbaun 23a Part Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, mack or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediate Causa (Final 10min disease or condition resulting in death) Examiner Examine physician end s the burial-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceusa (Disease or injury that initiated events resulting in deeth) Last Box 68760. 1 eumonia Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown mentio þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of To the Hospital or Attending Pt within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

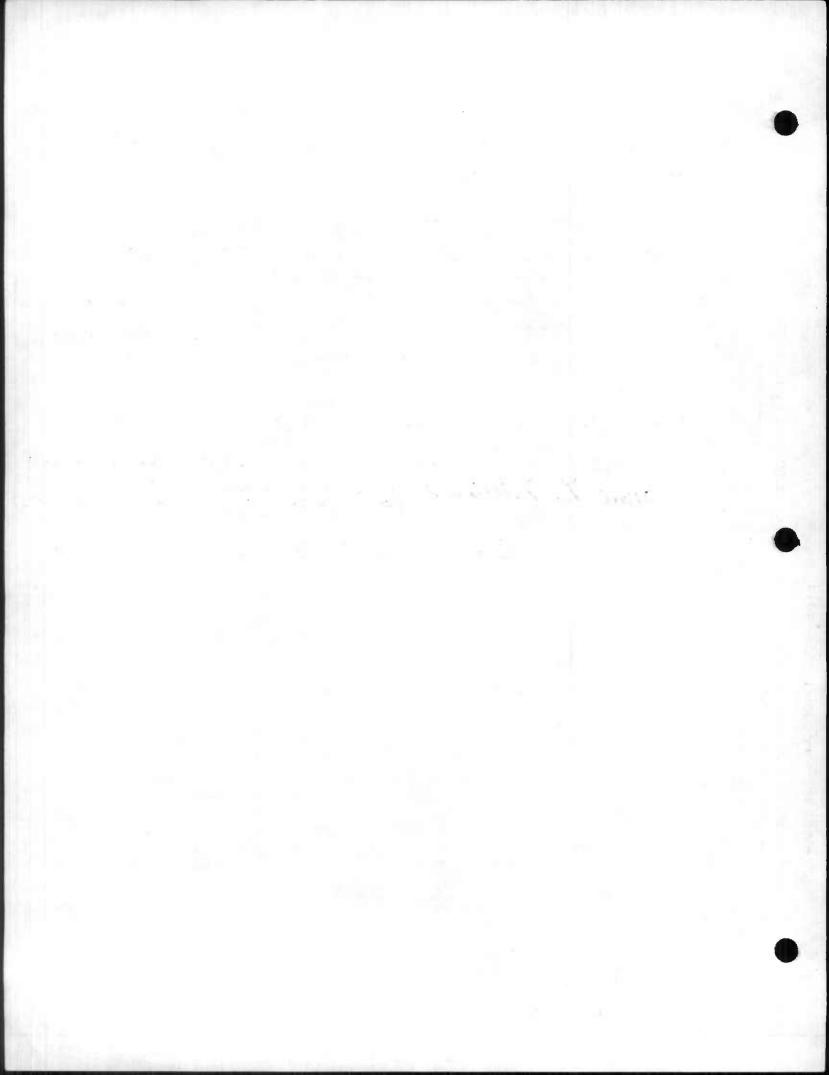
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (frem 23e) (Type, Print) ALAN H. ROHRER, MD, 1080 W. Patrick St, Frederick, MD 21703 32. Registra/s Signatura 31. Data filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar



	Pleas	se Type or State o	Print in I f Marylar	nd / Depa	artmen	t of H	lealth a				jible.		
	1. Decedent's Neme (First, Middle, Last)								Reg. No. 3 3 1 me of Death 3. 1 me of Death				
Physician /Medical		anklin	Dodson	dson 4b. City, Town, or					Movember 3 1999 12:30				
Examiner	Washington Cour						Hager		own Wash				
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Bi (Month, D		9. Birt	holace (Stete or Foreign	
Director	215-20-2999 Usual Residence of Decedent	1⊠M 2□F	74		Months	Days	Hours	Min.	Jan 9	, 1925		ginia	
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Hems Instrum	11. Meritel Status  1 Never Merried 2 Merrie  3 Widowed 4 Divorced	Armed Fo	2 X No	If Yes, specify Cuban, Mexican, Pu					cify Yes or N lican, etc.)	o- 14. R B	leck, White	American Indien, White, etc. White	
72 hours	15. Decedent	's Education		16a. Dece	dent's Usua	l Occup	ation			16b. Kind of	-		
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	17. Father's Neme (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle	e, Maiden Sum	ame)		
₩ ₽5.5 m	William		Doo	dson			Ma	ary	(	unknown	)		
Maryia d 2 should th and Men 7 le merke traumatic	19e. Informent's Neme/Reletionsh	nip (Type, Print)		19b. Maili	ng Address	(Street	and Numbe	or or Rural	Route Num	ber, City or Tox	m, Stete, 2	Zip Code)	
C = 01 F	Elsie Gill Dods	on - Wife	2	12202	2 Lake	evie	w Dri	ve, I	lagers	town, M	ary1a	and 21740	
Baitimore, leads that Department of Heal Important; if it has 2 any lojury or other ands.	20e. Method of Disposition  1												
Physician /Medical Examiner	23a. Pert 1. Enter the disease, or shock, or nath allure. List of the control of	complications that only one cause on e	rond	th. Do not ent	er the mode	e of dyir	ng, such es	cardiac o	respiratory	errest,		Approximete Intervel Between Onset end Death	
s, P.O. Box 68760, set that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last	c		or as a consec									
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f Vital Repairs the land the conficulty page									10	Yes 2 No		1 ☐ Yes 2 ☐ No	
Vital Formal Continues of the Continues	25. Was case referred to medical examiner?							of Death	(Check only	one)			
on of Vita ding Physician: h. After this certific funeral director, tion: To Be (	1 ☐ Yes 2 ☐ M5  27. Manner of Deeth 1 ☐ Naturel 5 ☐ Pending	28a. Dete (Mon	Impatient 2 Confirmation of this of the confirmation of the confir	28b. Time o Injury	1 2	8c. Injur	y et	2		sidence 6 00 how injury occ		cify)	
Division of To the Hospital or Attanding P Within 24 hours after death. To the Funeral Director: After It completely filled in by the funeral Medical Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place						28f. Location (Street end Number or Rurel Route City or Town, State)				urel Route Number,	
Hospita 24 hours Funeral letely fille	29e. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the examiner: On the beand man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tir in my o	me, date an opinion, dea	d place, a th occurre	nd due to the	e cause(s) end e, date and plec	menner a: e, end due	s stated. e to the ceuse(s)	
Vithin To the comp	29b. Signeture and title of certifier				290	. Licens	e number			29d. Date sig	ned (Mont	h, Day, Year)	
	) Q	14-6			D	2-1	1457 11				99		
	30. Neme and address of person v	who completed caus	se of death (Item	n 23a) (Type, OAk	Print)	Av	E. HA	AGER	stown	r. mo	20	142	
State Registrar	31. Dete filed (Month, Dey, Year)	who completed cause EED M -	legistratik Signa	ature	6.	A	bour	61					



99

9c. COUNTY OF DEATH

DOMERSET

10g. CITIZEN OF WNAT COUNTRY?

U.S

ORCHARD

Washington

Anne

3. TIME OF DEATH 500

8. BIRTHPLACE (State or Foreign

DELAWARE

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

n. State

MD

1 TYES 2 X NO

Black

2.0744

MD

21853

Approximate

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

1 YES 2 NO

29d. OATE SIGNEO (Month, Day, Year)

COMPLETION OF CAUSE

interval Between

Onset and Death

mas

REG. NO

Pauline Elizabeth Drummon BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

COMPLETED

BE

4 🗌 Homicide

29e, CERTIFIER

28

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	Panes
	Dermit
mest hours after death. Page 6 may be retained by the hospital or attending physician.	sky filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages
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FOR STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH nuline Stummond 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 3-8-19 DAYS 218-14-4352 HOURS 1 M 2 S.F 9e. FACILITY NAME (If not institution, give street and number) 96\_CITY, TOWN OR LOCATION OF DEATH 218-14-4332 Prince Manor DIRECTOR MANOKIN RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION MD QUARTER Omerse FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10875 K.lec 2182 obats 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, DIVE WAR OR DATES BY 1 TES 252 NO Specify 3 X Widowed 4 Divorced BE-COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life, Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTR (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) aboRER TARM notified at once. 17: PATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) obeet ei Gh T QU:SE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STER Mard Woods Lane pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Tow must OATE 1 Strief 2 Cremation 3 Re 4 Donation 5 Other (Specify) MAC. Cdonia 11-12-99 emetern 22. NAME AND ADDRESS OF FACILITY
ATTHORY E. Ward Funeral Home
30639 Hampdon Avo. Princess An medicel examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART I. Enter the disease, or complicatione that ceueed the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on each line. 0 **IMMEDIATE CAUSE (Finel** the signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, diseese or condition resulting in death) ceritoneal event, DUE TO (OR AS A CONSEQUENCE OF): Luden with other traumatic CERTIFICATION Sequentielly list conditions, QUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 6 Item 23 shows any Injury, PART II. Other eignificant conditione contributing to deeth but not racuiting in the underlying ceuse given in Part t. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? enera 1 TES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER:
4 K Nursing Home 5 Residence 8 Other (Specify) 1 TES 2 NO 1 Dinpetient 2 ER/Outpetient 3 DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural Pending DIRECTOR: After the hours after death w BY Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

TO THE FUNERAL DIRECTE
DE filed within 72 hours a
IMPORTANT: If Item 2 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print, GREGORIO M. BELLOSO, H.D 5302 CHINABERRY DR 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 0 8 1999

1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

investigation, in my opinion, death occured at the time, data and place, end due to the ceuse(s) and menner as stated

29c. LICENSE NUMBER

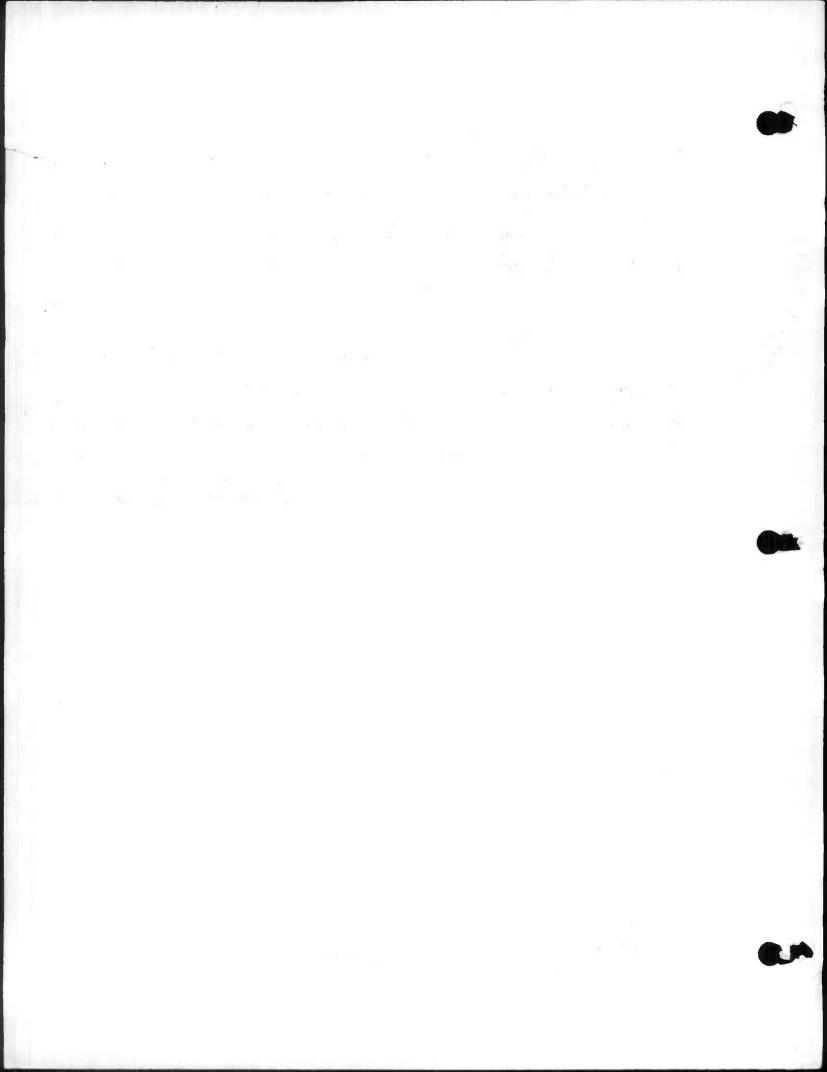
e Could not be determined

ATURE AND TITLE OF CERTIFIER

2 MEDICAL EXAMINER: On the basis of ax

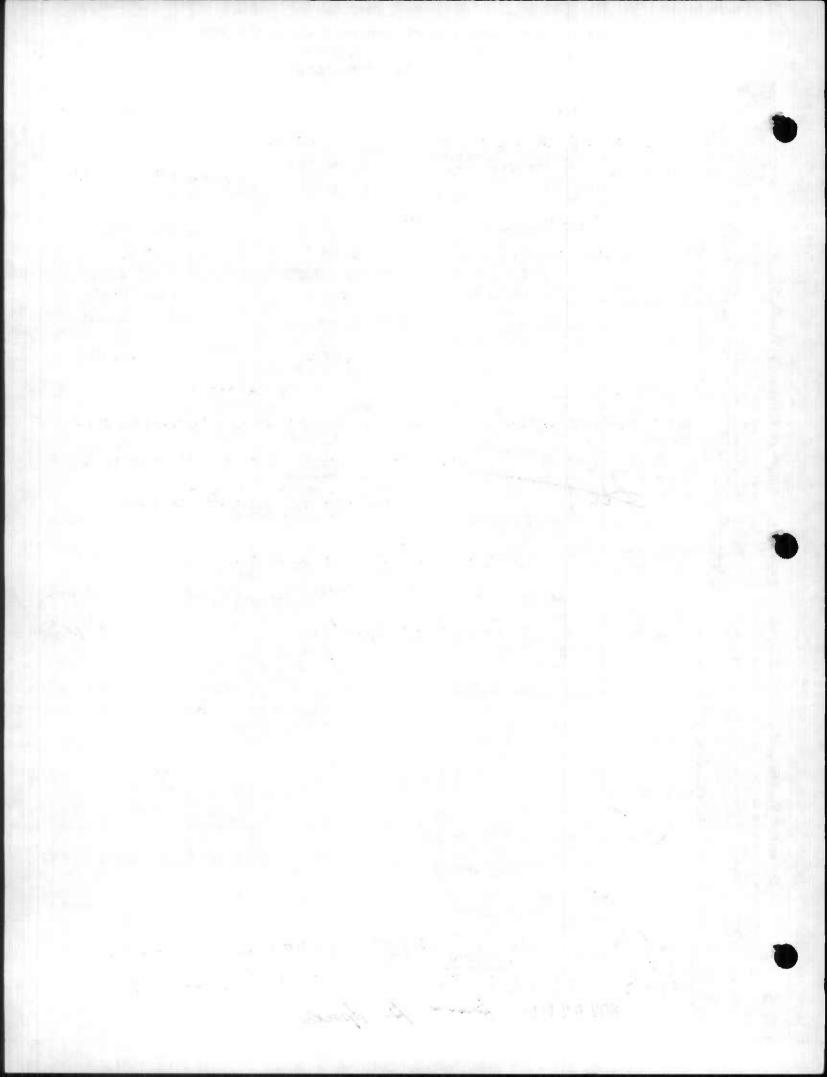


1801



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 36475

	Certificate of Death Reg. No.													
	1. Decedent's Neme (First	t, Middle, La	St)							2. Dete of De	eth	Vaar	3. Time	e of Death
Physician	Willie Mae	e Dalla	as							Month Octobei	Dey 28	1999	11	241
/Medical Examiner	4e Fecility Name (If not in			nber)				4b. City, To		cation of Death		ty of Deeth	12	9 <del>3</del> 1
LXammer	Peninsula i				tor			Salisbury Wicomico						
	5. Sociel Security Number			7. Age (In yrs.		If Under	r 1 Year				Wicomi		dace (Sta	te or Foreign
ineral rector	215-44-6548	1	□M 280 F	54	Yrs.	Months	Deys		Min.	8. Dete of Bird (Month, De May 18		Coun	MD	te or Foreign
<b>*</b> *	Usuel Residence of Dece 10a, Stete 10b.	County		10c. Ci	ty. Town or Le	ocation						1	Od. Inside	e City Limits
Example must be notified at by Funeral Director	26. 21.0	vorcest	er		ewark									′es 2½ No
fractives be notified Funeral Director	10e. Street end Number 6226 Basket	ewi tok	n Pd				Code 2184	1			10g. Citizen of		ntry?	
a e		-SWI CCI		Anna E anala ta	10				1-1-0 (0	-7		.S.	an India	
by Fun	11. Meritel Status  1 ☐ Never Merried 2  3 ☐ Widowed 4 🔀 🖺		12. Wes Dece Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2 []{No e			cify Cub	oan, Mexican, Puèrlo Rican, etc.)  Specify:			14. Race - American Indien Bleck, White, etc. Specify: Black		1,	
	15. E	ecedent's Ed	lucation de completed)		16e. Dece	dent's Usu	el Occu	petion during mos	et of worki	200	16b. Kind of	Business/In	dustry	
and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	Elementary/Secondary		College (1	-4or 5+)	life.	DO NOT u	se retire	ed)	H OF WORKI	ng .				
	12					En	gine	eer			Electronic			
	17. Fether's Neme (First,	Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Surne	me)		
	James Powel	1						Glady	s Ma	e Loadh	nolt			
traumatic To	19e, Informent's Name/F		Type, Print)		19b. Mail	ing Addres	s (Stree			I Route Number		n, Stete, Zip	Code)	
1	Lanetta Dall		1006	Read	rlin	Park	Driv	e, Sali	shurv	MD 2	1804			
other	20e. Method of Disposition		-500-2	20b. l	Plece of Disp	osition (Ne	me of		1	Dete	20c. Location			9
8	1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐ 0			state	wesle				7 1	1/4/99	4/99 Snow Hill, MD			
용소용	21. Signature of Fureral Service Conses  22. Name end Address of Fecility  Lovering NJ Village on Themses													
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximate Intervel Between Consett and December 1.1.													
ling physicien end e as the buriel-transit  Medical Examiner											10 y	vs_		
		•	d									1		
deteched for us	Part II. Other significent	conditions o	ontributing to de	ath but not res	sulting In the u	underlying	cause g	iven in Part	i.	23b. Dld	tobecco use o	ontribute to	o the cau	se of death?
by Phy										1)	Yes 2□ No	3 □ Pro	bably 4	Unknown
should										24a. Wes	en eutopsy rmed?	ev	ere eutop reilable pri empletion deeth?	
rector, page 2										10	Yes 2 No			2□ No
5 0	25. Was case referred to	medical						26 Plan	e of Dooth	(Check only o				
o Be	exeminer?		Hospital:	o N	1000		0, 0	her _			_	wh (C)	% . )	
- F	1  Yes 2 No 27. Manner of Deeth		1 ∐ I		ER/Outpetie		UA	4 L N	-	me 5 Resi			γ)	
tion	1 Natural 5	Pending Investigation	(Mont	h, Dey Year)	Injury	М	28c. Inju Wo	ork? ]Yes 2□						
Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	oome, farm, st				] No  28f. Location (Street end Number or Rurel Route Num. City or Town, State)				Number,	
completely filled in by the Medical Certificat	29a. Certifier (Check only one)	Certifying Phi fedical Exam	yelclan: To the niner: On the be end menn	sis of examina	owledge, deal ation and/or Ir	th occurred	at the t	ime, date ar opinion, dea	nd plece, a	and due to the ed at the time,	ceuse(s) and i date end place	menner as s e, end due t	itated. o the ceu	se(s)
Me Me	29b. Signature and title o	certifier	one men	c. arod.		29	c. Licen	se number		T	29d. Date sign	ned (Month.	Dey, Yes	17)
8	1 Tatus	in	MA	Low	-ME		I	)46	490	C	1/-	2-5	9	
	30. Nemv end eddress of	person who	completed caus	e of deeth he	m 23a) (Type	Print)		1111	, ,	1	0.101	2		
10	428 Cl	. YY	KILLE	- 51	-	SINC	W	Hil	1, 1	11) 3	2/80	3		
State	31. Date filed (Month, De	/ Yeer) 10	32. R	egistrer's Sign	ature	4	1							



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	4 December 41 4mm - 1 111	W. 4 A)				of Death			leg. No.			
Physician /Medical	Decedent's Nama (First, Midd		Laray	Eby				2. Data of Dea Month Novembe	Day	Year 1999	3. Tima of Death 12:10 PM	
Examiner	4a Facility Nama (If not institution	own, or L	ocalion of Death 4c. County of Deeth									
	Wahi	ington Cour	ty Hosp	ital		Hage	rsto	wn Washingto			on	
uneral rector	5. Social Security Number	6. Sex 1∭ M 2□ F	7. Age (In yrs. las 16	Monthe Dave House Min			8. Data of Birth (Month, Day August 30	), 1983	9. Birthplace (State or For Country) Marylar			
	Usual Residence of Decedent											
Examiner must be notified at by Funeral Director	10a. Stata 10b. Count									11	Od. Inside City Limits	
ct	MD. Washi	ngton	Wi	llam	sport						1 □ Yas 2 No	
al Dire	10e. Street and Number 14256 Clear	Spring Rd.			10f. Zip Cod 217				U.S.A.		try?	
by Funeral Director	11. Marital Status  1 X Nevar Married 2 Mar 3 Widowed 4 Divorced	med 1 Yes	No		Was Decedent if Yas, specify ( 1 ☐ Yes 2 💢			pecify Yas or No- o Rican, atc.)  14. Race - America Black, White, e			etc.	
Completed by	15. Deceder	nt'a Education est grade completed)		16a. Deced	dent's Usual O	cupation ona during mo	st of work	king	16b. Kind of B	usiness/Inc	lustry	
mpte	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work do				0 1 1 -			
	10			Fa	rm Work					cultur	^e	
To Be	17. Father's Nama (First, Middla, Last) C. Lester Eby Sr.  18. Mother's Nama Doris								Maiden Suman	na)		
To	19a. Informent's Name/Ratationship (Type, Print)  19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)											
	Carl L. Eby Jr. 17009 Broadfording Rd. Hagerstown, Md. 21740											
	20a. Method of Disposition  20b. Place of Disposition (Nama of cematary, crematory or other place)  20c. Location - City or Town, State Clear Spring Mennonite Church Cemetery  20c. Location - City or Town, State Clear Spring, Md.											
BOOG PURIOR	21. Signature of Funaral Service  H. Mustinia	Licensee	-Jn.	22	2. Name end A Zimme rm	an And	Son	Funeral Greenca	Home I	nc. Pa. 17	7225	
ian	23a. Part1. Entar the disease, o shock, or heart lailure. Lis	r complications that ca t only ona cause on as	used tha death. ich lina.	Do not ent						0	Approximata Intarval Between Onset end Death	
al er	Immediata Causa (Final disaesa or condition rasulting in death)	a	(Bue to (oc.	1 CS	juanes of)	1	90	20	aura	2		
er Examiner	disassa or condition rasulting in death)	a	(Bue to (or a	s a consecutive	juence of):	al	100	tsphy	exia	2		
edical Examiner	disaesa or condition	a b c d	Due to (or a			al	1	tsphy	exia			
sician/Medical Examiner	disaesa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events	a b c dons contributing to dea	Dua to (or a	s a conseq	uance of):	a given in Part		23b. Did to			o the cause of death?	
be detached for use as the buriet-trensit  by Physician/Medical Examiner	disaesa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last	a b c d	Dua to (or a	s a conseq	uance of):	a L			an autopsy	3 Prot	ara autopsy findings ailable prior to mpletion of causa	
by Physician/Medical Examiner	disaesa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last	a b c dons contributing to det	Dua to (or a	s a conseq	uance of):	a l		1 U	an autopsy med?	3 Prot	ara autopsy findings ailable prior to mpletion of causa deeth?	
interched for use as the buriel-trensit  Physician/Medical Examiner	disaesa or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last		Dua to (or a	s a conseq	uance of):			1 🗆 1	an autopsymed?  ✓as 2□No	3 Prot	ara autopsy findings ailable prior to mpletion of causa	

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification

2 Accident
3 Suicide
4 Homicide

: Williamsport, Md

investigation
6 Could not be detarmined

28a Placetot Injury - At home, farm, street, lactory, office

28a Placetot Injury - At home, farm, street, lactory, office

28i. Location (Street and Number or Rura) Route Number,

City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. License number

29b. Signatura and title of certifier

O.C.M.E.

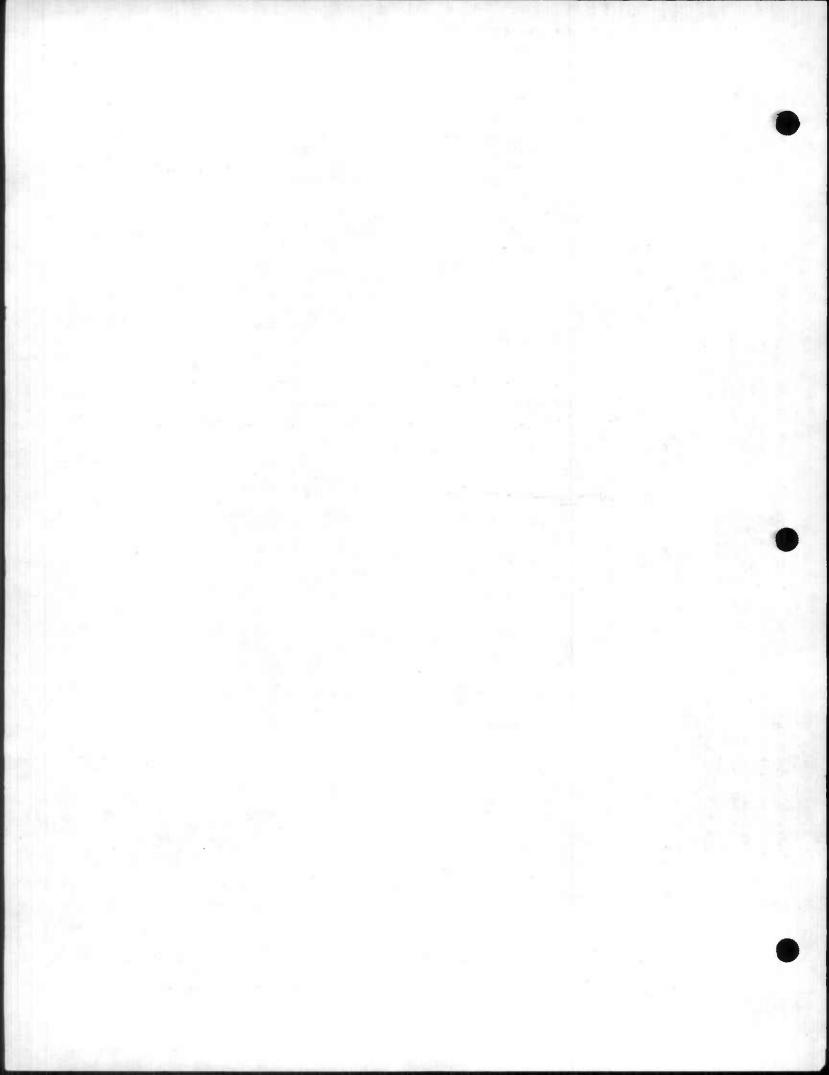
November 5, 1999

30. Nama and ad tress of person who completed cause of eath (Item 23a) (Type, Print) estaner 106

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data liled (Month, Day, Year) NOV 08 1999 32. Redistrar's Signatura



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day Physician GEORGIA DELORIS November 4, 1999 ERICSSON 7:40 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick # Under 1 Ye If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Months Hours March 30,1936 W. 235-54-2251 Virginia **Usual Residence of Decedent** 10s. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Frederick Frederick 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 222 Broadway St., Apt. 302 21701 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indien, Black, White, atc. 1 Never Married 2 Married 1 Yes 25 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify P 3 ☐ Widowed ♣ ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Tailor/ dry cleaner 17, Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Clyde Haynes Cozy Randolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia D. Ericsson / daughter 74 Wilderness Path / Dallas, Georgia 30132 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-8-99 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 22. Nama and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike/ Frederick, MD 21702 son 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) Due to (or as a consequence of): ulunonar Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 149 Due to Part fl. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Discase 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

**Funeral** 

Director

I show

pernit. Pages 1 and 2 should be flied within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show pinjury or other traumatic avent, the Maxical Examinal must be notified an once.

Baltimore, Maryland 21215-0020

death with the Maryland

sician and burial-transit The lew requires that the death certificate be executed physician s the buria Box 68760. U88 P.O. of Vital Records, page 2 s or Attending Physician: this funerel Aftert Division within 24 hours after deeth. To the Funeral Director: A the filled in by

Examiner Physician/Medical þ Completed 1 ☐ Yas 25. Was case referred to medical axaminer? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28c. tnjury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

Limited Call Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and manner stated.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

**NOV 08** 

29c. License number 29d. Data signed (Month, Day, Year)

H. Kohrer

ai 31. Data filed (Month, Day, Year) 32. Registrar Signature

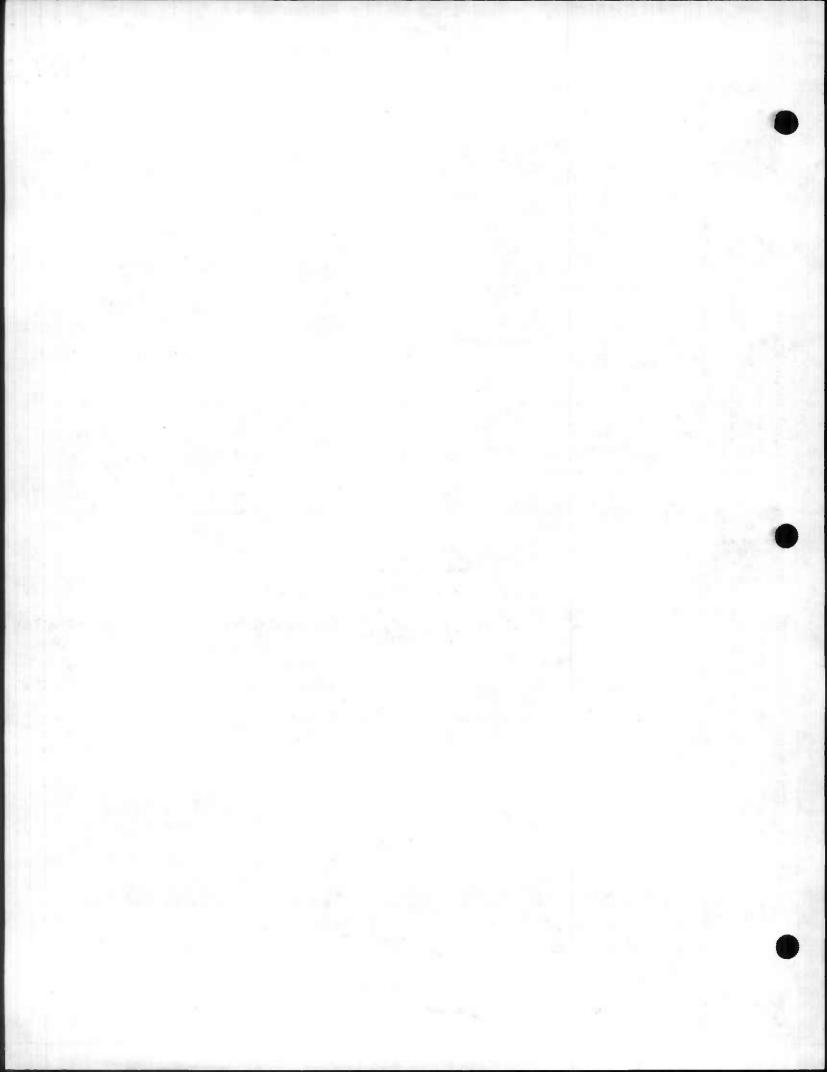
1999

State Registrar

completely

Medical

To the Hospital



# Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

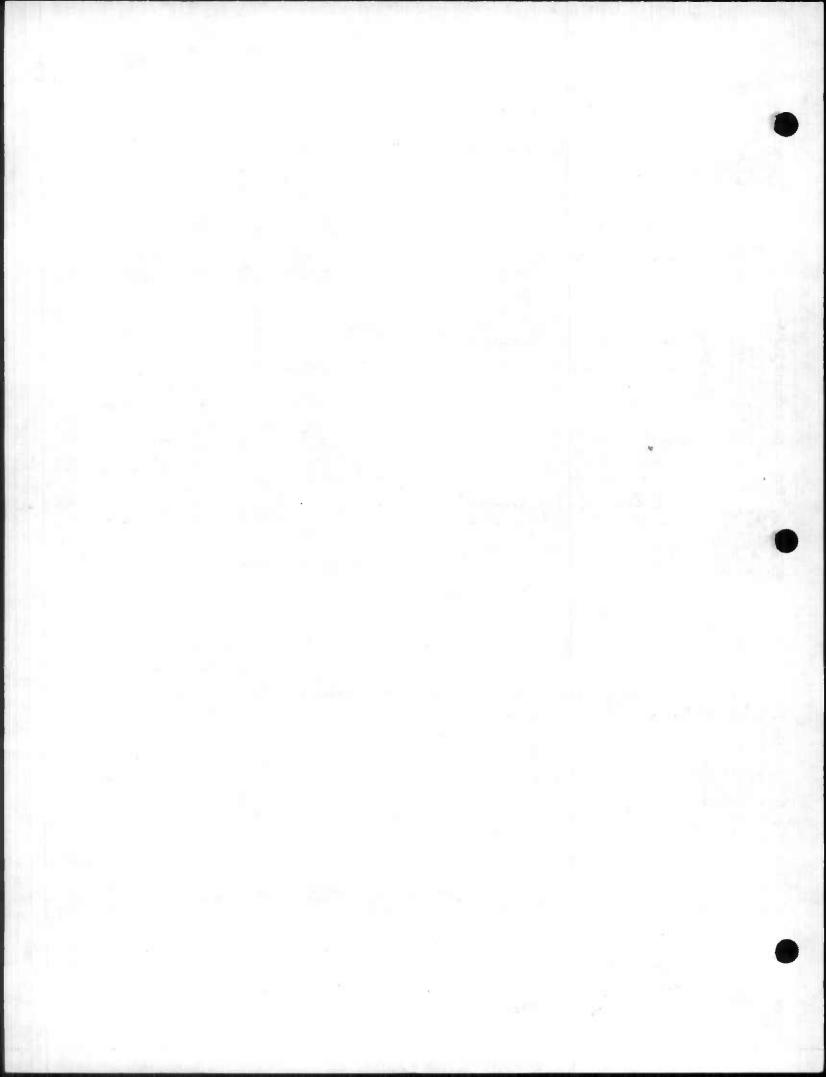
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Des Physician 31, 1999 William C. 23:37 PM Oct. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADVENTIST HOSPITAL

ex 7. Age (In yrs. last birthday) fl Under 1 Year
Months Days ROCKVILLE
If Under 24 Hrs. 8. [ MONTGOMERY 5. Social Security Number CROVE 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funera! Hours 1 M 2□ F 060-12-6054 81 Director June 17, 1918 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mantal Hyglens.
Intil if them 27 le marked ordher than "natural", or items 23s or 28s-f show any or other training the notified at any or other training event, the sendes Especials. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Montgomery Germantown 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 23121 Bank Barn Court 20876 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 1 Yes 2 No If Yes, Give 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 □ Divorced Year or Dates: White WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Core Maker Iron Foundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 William C. Enck, Margaret Murray 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 23121 Bank Barn Court, Germantown, Maryland 20876 Dianne J. Leiter - Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete permit. Pages Department of Important: if it any injury or o 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 11/4 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Damascus, 20872-0117 Maryland Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Arrhythmia Minutes Examiner Due to (or as a consequence of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): The law requires that the death certificate be exe physician the burtal Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Vunknown Congestive Heart Failure ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed Renal Failure certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 88 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Afflac Division or Attending 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident To the Hospital or Attend within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3∏ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 ☐ Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 1, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 809 Veirs Mill Road, Rockville, Maryland David Holden 1999 Registrar Signature State

DHMH 16 Rev 6/95

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 1999 NOVEMBER Marjorie C. Fender 5 /Medical 4b. City, Town, or Location of Deeth 4a Facility Nema (If not institution, giva street and number) 4c. County of Death **Examiner** Lorien Nursing Home Belcamp HARFORD If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 8. Deta of Birth (Month, Day, Yaar) 7. Aga (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 XX Yrs. 99 1900 North Carolina 212-14-2398 Director Usuel Residence of Decadent the Maryland 10a Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Harford Aberdeen 10e. Street end Numbar 10f. Zip Coda 10g. Citizan of What Country? 765 Gilbert Road 21001 U.S.A. Funeral 14. Race - Amarican Indian, 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 11 Marital Status Black, Whita, atc. 2 should be filed within 72 hours after nend Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yas ♣ No If Yes, Give Yaar or Datas: 1 Naver Married 2 Marriad 1 Yas 2 No Spacify: λq Specify: White 3€Widowad 4 □ Divorcad FENDER Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 0 Manager Restaurant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Mack Higgins Laura Todd MARSORIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 st Department of Heelth enc Important: If frem 27 is n Mrs. Evon T. Brinegar (Daughter) 765 Gilbert Road, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cematary, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Othar (Spacify) infury or Bel Air Memorial Gardens 11/8/99 Bel Air, Maryland 21. Signature of Furnal Sarvice Licensee 22. Nama and Addrass of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Entar the disaasa, or complications that caused the death. Do not antar the mode of oring, such as cardiac or raspiratory arrast, shock, or heer failure. List only ona ceusa or each the. Approximate tntervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disaasa or condition resulting in daath) **Examiner** Examiner physicien end the buriel-transit certificata be executed Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaasa or Injury Dua to (or as a consequence of): Physician/Medical that initiated avants rasulting in daath) Last Dua to (or as a consaquance of) 50 esn ficant conditions contributing to death but not resulting the underlying causa given in Part I. P.O. Part II. Other sign 23b. Dld tobacco use contribute to the cause of deeth? 1 ☐ Yes 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performed? Completed cartificata has 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only one) 2 X No Hospital: Other: Sursing Homa 5 Rasidance 6 Othar (Specify) 2 2 ER/Outpetient 3 DOA 1 Yas 1 Inpatiant this funaral 28d. Dascribe how Injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? of a standing Parties of the death. Natural 2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datamined Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida 24 hours e Priffying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. The dical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check of one) To the Within 2 29b. Signature

completed cause of deeth (Item 23a) (Type, Prin

32. Registrar's Signatura

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Registrar

30. Nama and address of person who

LWON

31. Dete filed (Month, Day, Year)

5.5. 30 AUR

Secretary for a con-

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 99 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath NOV. 1998 ar Shirley Lorraine Forrest 10:00 A.M. 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 115 Water St. Frederick Thurmont 5. Social Sacurity Number If Undar 1 Yaar I If Undar 24 Hrs. 8. Data of Birth Month, Day, Yaar) March 3, 1955 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Days 1 □ M 2 🖫 F 164-46-6469 44 Yrs. Penrisulvania Usual Residence of Decedant 10b County 10c. City, Town or Location 10d. insida City Limits Frederick Thurmont 1 X Yas 2 □ No 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 115 Water St. 21788 U.S.A. 11. Marital Status 12. Was Dacedant Evar In U,S Armad Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Seamstress Factory 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Floyd Calvin Manning Mary Elizabeth Welch 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

14 Tacoma St. Thurmont, Md.

Smithsburg Crematory Nov. 4. 1999 Smithsburg. Md.

20c. Location - City or Town, Stata

20b. Placa of Disposition (Nama of camatary, cramatory or other placa)

Physician /Medical

**Physician** 

/Medical

**Examiner** 

10a. Stata

Md.

20a. Mathod of Disposition

Meredith F. Forrest Jr. (Son)

1 □ Burial 2 Cramation 3 □ Ramove

<sub>o</sub>Funeral

Director

must be notified at

28a-f

9

or items 23e

permit. Pages 1 and 2 should be filed within 72 hours aftar d
Department of Health and Mentel Hygiene.
Important: If Itam 27 is marked other than "naturel", or frem
eny injury or other treumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0020

Funeral Director

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Be Completed

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deeth with the Maryland

**Examiner** or Attending Physician: The law requires that the death certificate be executed

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certificate this After t

death.

ending physiclan or use as the burial pege 2 To the Hosping.
within 24 hours efter death.
To the Funeral Director: A'

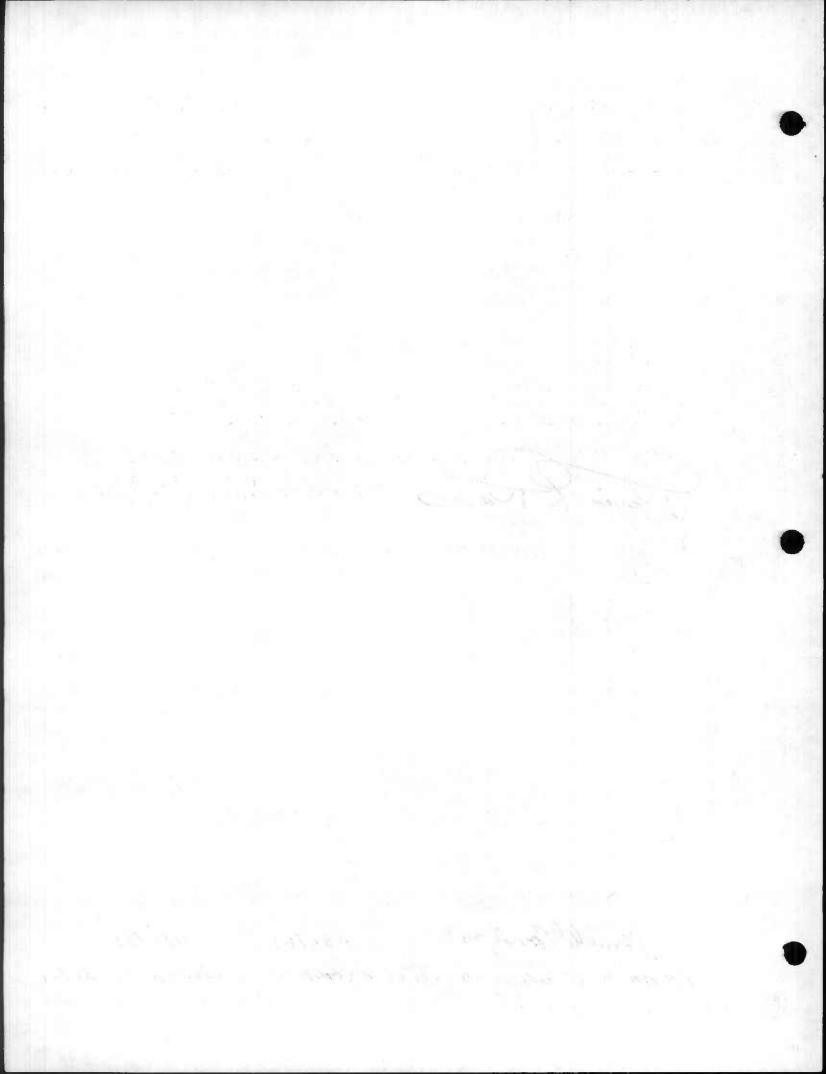
Division of Vital Records, P.O. Box 68760,

Donation 5 Other (Specif	Sm Sm	ithsburg Cren	natory Nov. 4	,1999 Smiths	burg, Md.					
21. Signature of Function Service locar	Navi	22. Nama and Davis Fu	Addrass of Facility Lineral Home S	2525 Bradbury mithsburg,Md.	1 Aue. 21783					
23a Fart1. Entar tha disaasa, or com shock, or haart failura. List only	pilcations that causad tha daa ona causa on aach lina.	ith. Do not antar tha mode of	of dying, such as cerdiac or	raspiratory arrast,	Approximata Intarval Batween Onsat and Death					
Immediata Causa (Final disaasa or condition rasulting in daath)	METASTAT	7c ADENOG	ARCINOMA	OF PANCRES	AS 10 MENTHS					
	Dua to (	(or as a consequance of):								
Sequantially list conditions, if any, laading to immadiate cause. Entar Underlying	b Dua to (or as a consaquance of):									
Causa (Diseese or Injury that initiated avants rasulting In deeth) Last	C. — Dua to (or as a consaquance of):									
Part II. Other significent conditions of	ontributing to death but not re-	sulting in the underlying cou	se diven in Pert I	23h Did tohecco use co	ontributa to the cause of death?					
	on nothing to death but not re-	oding in the didenying coo.	so givan in Fatt I.	1 □ Yes 2 No	3 Probably 4 Unknown					
				24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to complation of causa of death?					
				1 Vas 2 No	1□Yas No					
25. Was cesa rafarred to medical axaminar?			(Check only ona)							
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27. Manger of Death Naturel 5 Panding Accident investigation		28b. Tima of Injury M	Injury at Work? 1 Yes 2 No	d. Dascribe how injury occur	rred					
3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide datermined	28a. Place of Injury - At h building, etc. (Speci	oma, farm, straat, factory, o	f. Locetion (Straat and Number or Rural Routa Number, City or Town, Stete)							
29e. Cartifiar (Check only one)	ysicien: To the best of my kno niner: On the basis of axamina and manner stated.	owledge, daeth occurred at tation and/or investigation, in	he time, data and plece, end my opinion, daath occurrad	d dua to tha causa(s) and mat the time, data and place,	ennar as statad. and due to tha causa(s)					
29b. Signature and title of certified	Cours, no		cansa number 8 31761	29d. Data signa	nd (Month, Day, Yaar)					
30. Name and address of person who	complated ceuse of death (transcription)	501 W, SE	PATH ST.	FREDERICK	MS 21701					
31. Data filad (Month, Day, Year)	32. Registrar's Signa	atura	1		,					

State Registrar

NOV 0 9 1999

32. Registrar's Signatura



State

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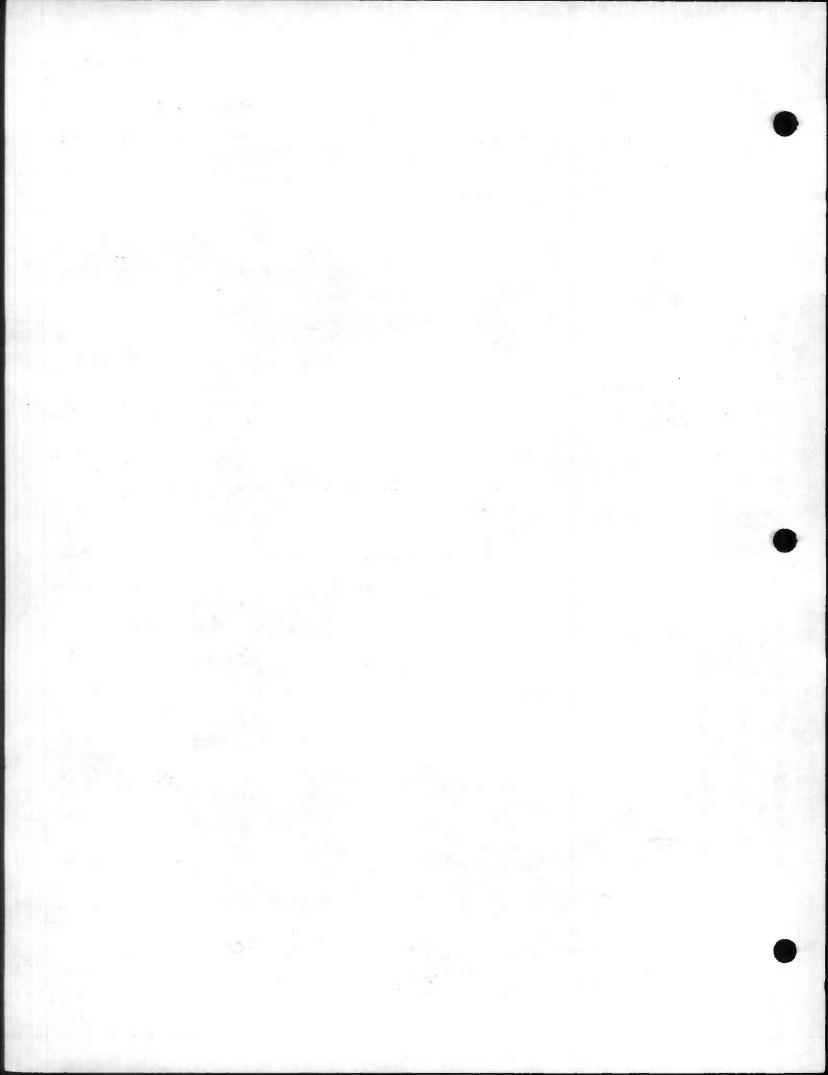
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31. Data filed (Month, Day, Year) NOV 1 6

11110 Med. Canpus D.



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** October 29, 1999 10:30 AM William . **Bradley** Fout /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 1418 West 11th Street 8. Dete of Birth June 27, 1924 If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days Months Hours Maryland 217-12-1922 75 Director Usual Residence of Decedent the Maryland 10a. Stata permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiane. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any Injury or other traumatic event, the Hedical Examination and page. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 des 2 No Director 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 1418 West 11th Street 21702 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No. If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian. 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White à 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Security US Government 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Paul Fout Mabel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mrs. Ruby A. Kline, sister 7902 Juniper Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from Stata Mount Olivet Cemetery, Nov. 1, 1999 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home MO0255 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one caused on each line. 21701 Frederick, Md. Approximata Interval Between Onset end Death **Physician** Immediate Causa (Final disease or condition resulting in deeth) /Medical Examiner to (or es a consequence of): Physician/Medical Examiner attending physicien and for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1) 2 No 3 Probably 4 Unknown OI Scase à 24b. Were autopsy tindings available prior to completion of causa of deeth? certificate has been si rector, page 2 should Be Completed 24a. Wes en eutopsy **65ed** 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) edicai Certification: To 1 Yes 3KLNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

The lew requires that the death certificate be executed 68760 Box P.O. of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I Division

Baltimore, Maryland 21215-0020

State Registrar 29e. Certifier (Check only one)

29b. Signatura and title of certifier

30. Neme end address of peri

31. Date filed (Month, Dey, Year) NOV 02 1999

32. Registrar's Signatura

end address of person who completed cause of death (Nem 23a) (Type, Print)

Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, Md. 21701

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

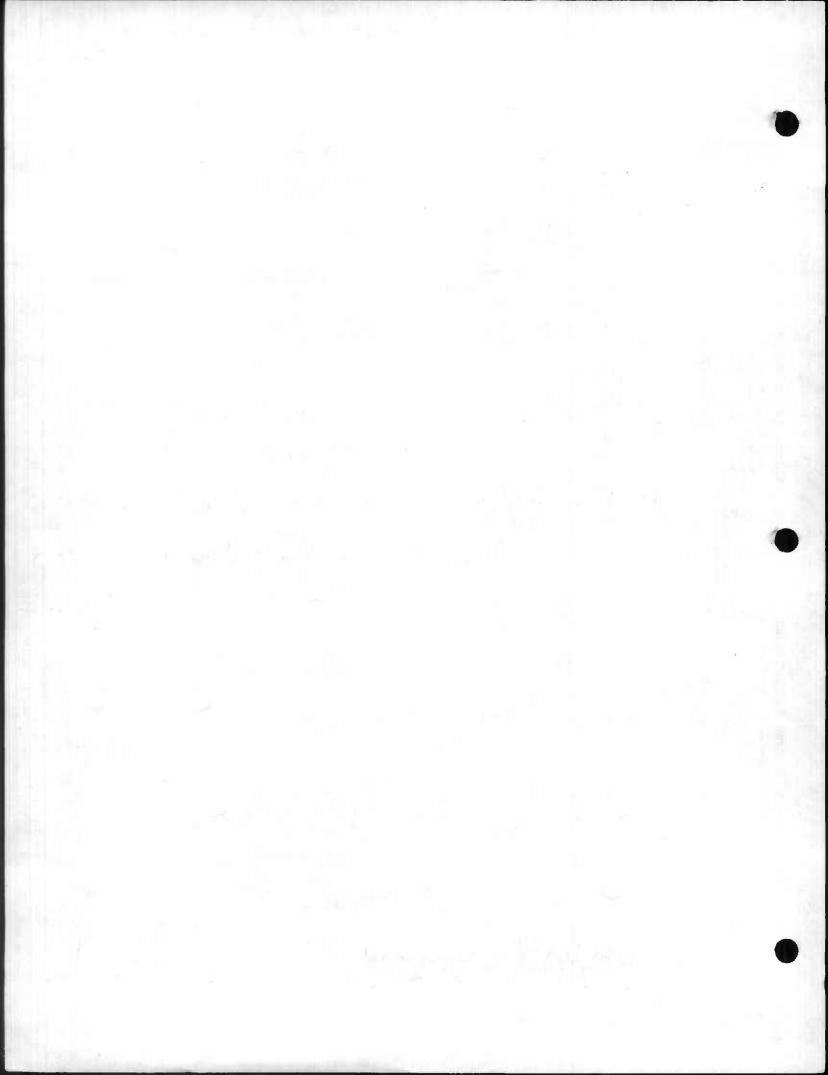
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D16428

29d. Date signed (Month, Day, Year)

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 36483 amend item 1 per phy G779 1/14/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phy

/M Exa

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permit. Pagas 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other than "natural", and items 23a or 28a-f ahow any Injury or other than the route and any Injury or other than the route and

Baltimore, Maryland 21215-0020

Physici /Medic Examin

To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Orabelle Huberts 4a. Fecility Name (If not institution,			luberta	South	-		wn, or Lo	October cation of Death	T	1999   12:	20 p
National Luthera	n Homo	,				Pock	vill	0		tgomery	
		. Age (In yrs. la	st birthday)	If Under	r 1 Year	If Under		8. Date of Birth		9. Birthpiace (Sta	ate or For
214-09-6816	1□ M 2□XF	80	Yrs.	Months	Days	Hours	Min.	(Month, Day, July 10		Country) Marylan	
Usual Residence of Decedent  10a. State 10b. County		10a City	Town or L								
Too. County		TOG. City,	, Town or Lo	Cation						10d. Insid	
Maryland Washir	igton		Hager	stown						N-	Yes 2
10e. Street and Number				10f. Zip	Code			10	g. Citizen of	What Country?	
1057 Beechwood I	)rive				217	40			U.S.A		
11. Marital Status	12. Was Decede	ent Ever in U,S	3. 13.	Was Dece	dent of H	Ilspanic Ori	gin? (Spe	cify Yes or No-	14. Ra	ce - American India	n,
1 Never Married 2 Married	Armed Force 1 ☐ Yes 2	XNo	J,S. 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica				i, Puerto I	Hican, etc.)	Ble	eck, White, etc.	
3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dete			1 🗆 Yes	2[ <b>X</b> [No	Specify:			Speci	y: White	
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(Specify only highest of			(Give	kind of wo	rk done d	durina mos	t of workir	ng			
Elementery/Secondery (0-12)	College (1-4	lor 5+)	S	ecret	2237				Hoe	pital	
17. Father's Name (First, Middle, La		l l		ECTEL	ary	18 Moths	r's Name	(First, Middle, M			
Hubert Ragan Sou							edia Sto				
19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street	and Numbe				, State, Zip Code)	
Ragan E. Gross -	- Son					Court	Sp	ringfiel	ld, Va	. 22152	
20a. Method of Disposition	□ D	0.01	ace of Dispo	sition (Nan	ne of other place	ce)	Date 2	Oc. Location	- Clty or Town, Stet	е	
1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate	est H				1.1	/1/99 H	Jacere	town, Mar	vlar
21. Signature of Funerel Service Lic	ensee	I	7			ss of Fecilit		nnich Fi			Jiui
916	M	1	7							, Md. 217	40
Sa Part1. Enter the disease, or co	Merr	ned								, Mu. 217	40
disease or condition resulting in death)	pue to (or	as a consec	quenca of):	Too	not	P	· Par	a	10	lay	
Commencially list and divine	as a consequence of):						C	1 Y-C	ar;		
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Cause (Disease or Injury that initieted events	c	HIV	rial	A .	MV	1110	470	(/Y)		1 500	OU
resulting in death) Last		Due to (or e	es e conseq	uerice of):						7	
	d										
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								24a. Wes an	autopsy	24b. Were autop available pr	sy findin
								portonn	001	completion of death?	of cause
								1 N V-	2001		n□ M-
26. Was once referred to medical								1 □ Yes		1 🗆 Yes	2□ No
25. Was case referred to medical examiner?	Hospitai: 1 ☐ Inpa				Othe	or:		(Check only one			
1 Yes 2 No	R/Outpatien		PA	4 12 Nu		ne 5 Resider					
1°E/Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe how	v injury occui	rred	
2 Analytens investigati	bo	M 1 Yes 2 No									
E-177 LANGUAGUE	d 28e. Placa of building.	Injury - At hom, etc. (Specify)	ne, farm, str	eet, factory	, office		2	8f. Location (Str. City or Town,		ber or Rural Route I	Vum <i>ber</i> ,
3 Suicide 6 Could not determine		, , , , , , , , , , , , , , , , , , , ,							,		
3 Suicide 6 ☐ Could not											
3 Suicide 4 Homicide 6 Could not determine 29a. Certifier 1 Certifying P	Physician: To the be aminer: On the basis and menner	s of examinatio	edge, death on and/or inv	occurred of estigation,	et the tim in my op	ne, date and pinlon, deet	d place, a h occurre	nd due to the cau d at the time, de	use(s) end m te end placa,	anner as stated. and due to the ceu:	se(s)
3 Suicide 4 Homicide  6 Could not determine  29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	Physician: To the be aminer: On the basis and menner	s of examinatio	edge, death in and/or inv	estigation,	in my op	oinlon, deet	d place, a h occurre	d at the time, de	te end placa,	and due to the ceu	
3 Suicide 4 Homicide  6 Could not determine  29a. Certifier (Check only) 2 Medical Exp	<b>iminer:</b> On the basis	s of examinatio	edge, death on and/or Inv	estigation,	the time in my op	oinlon, deet	d place, at h occurre	d at the time, de	te end placa,	anner as stated. and due to the ceus	

26033 Ridge Road

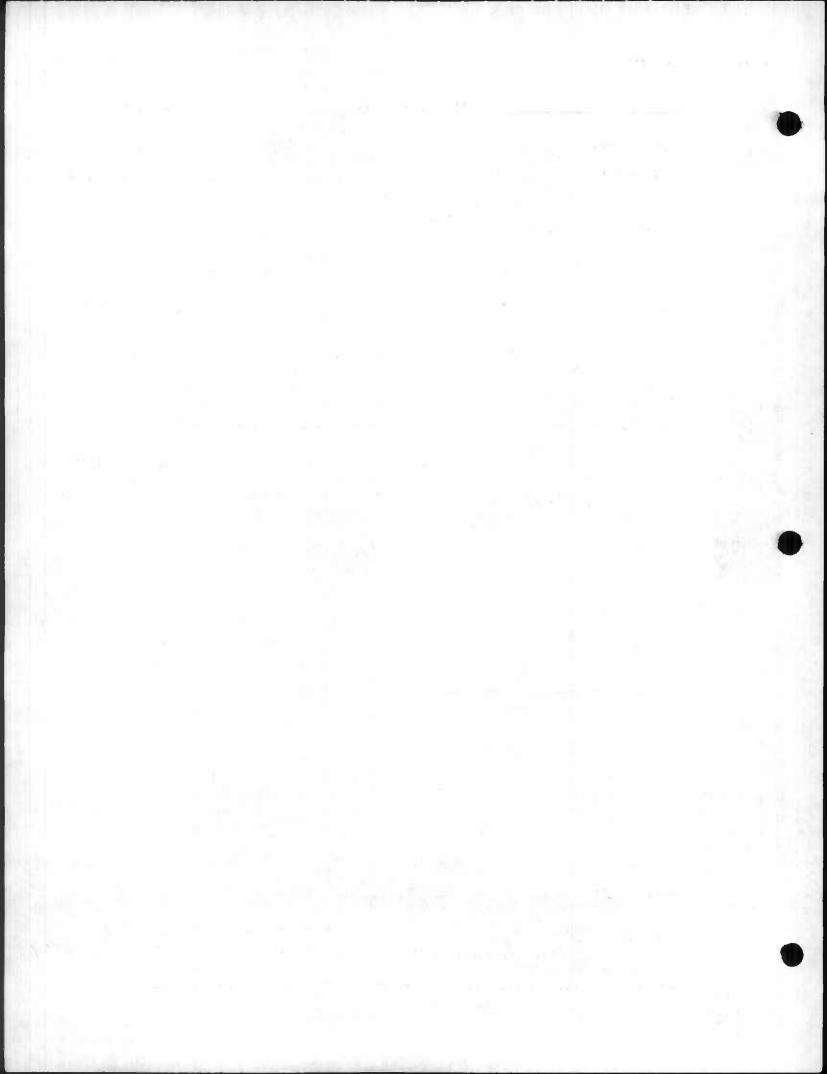
32. Registrar's Signature

Damascus, Maryland 20872

State Registrar

Charles W. Karesh, M.D.

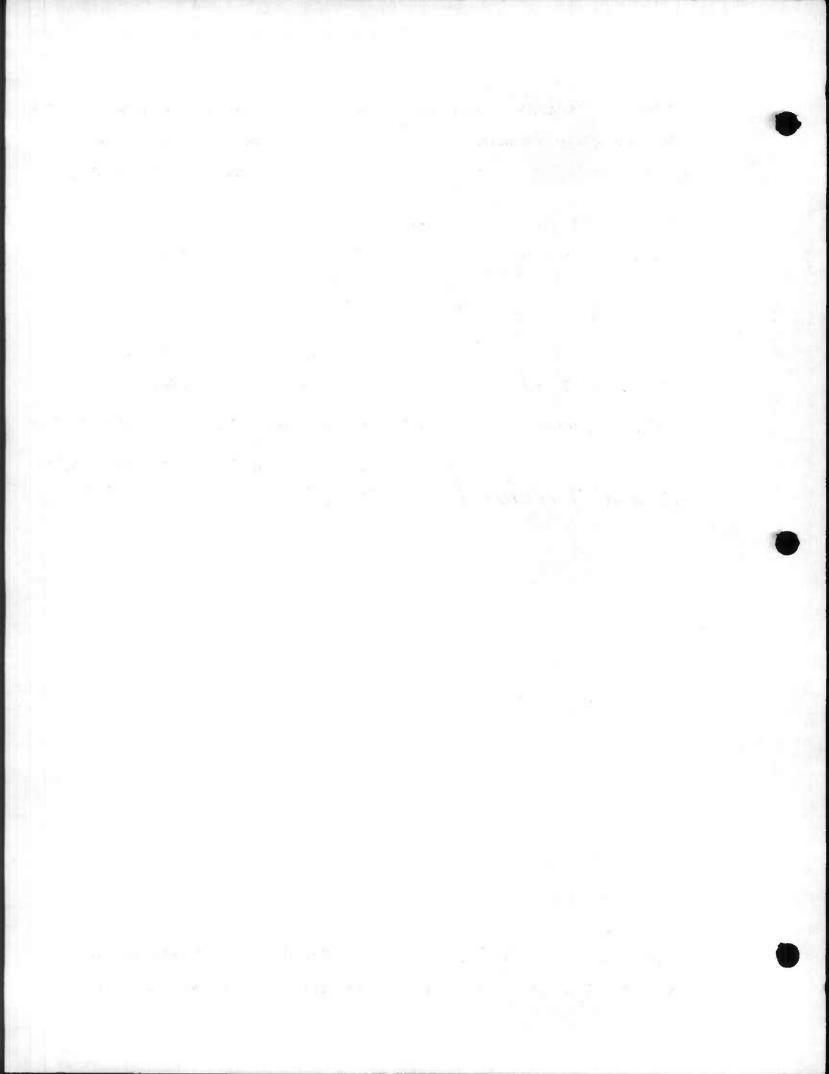
31. Date filed (Month, Day, Year) NOV 02 1999



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State of Maryland / Department of Health and Mental Hygiene 99 36481

				01410	· maryia		Certifica		Death		eg. No.		040	1 14
	Dharia		1. Decedent's Neme (First, Middle	e, Last)						2. Dete of Dee		Yeer	3. Time of	Death
Ļ	Physic /Medi		EDWIN B	LAIR	GLES	NER	S	₹		October		999	6:1	15 PM
	Exami		4e. Fecility Neme (If not institution	n, give street end nui	mber)				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth		
			Washington Co						Hagerston		Washi			
	Funeral Director		5. Social Security Number 216-14-6594 Usuel Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs 76		rs. If Unc	ler 1 Yeer s Deys		8. Dete of Birth (Month, Dey May 25,	Year) 1923	9. Birthp Coun Mary	iece (Stete o try) /Land	<i>r Foreig</i> n
	and *=		10e. Stete 10b. County		10c. C	ity, Town	or Location				10d. Inside Ci			ity Limits
	Mery	JO.	Maryland Wash	nington		Wil.	liamsp	ort					1 🗆 Yes	2√2 No
	28e	rec	10e. Street end Number	11100011				Zip Code		1	0g. Citizen of	Whet Coun	try?	
	N With	Funeral Director	16718 Virginia	a Avenue				2179	5		USA		•	
	deed deed	ner	11. Maritei Stetus	12. Wes Dece	edent Ever in U	J,S.	13. Wes Dec	edent of	Hispanic Origin? (Sp cen, Mexican, Puerto	acify Yes or No-		e - Americ		
Maryland 21215-0020	be filed within 72 hours efter deeth with the Meryland tiel Hyglene. Id other than "natural", or flems 23s or 28s-f show event, the Medical Exercipes must be notified at	by	1 ☐ Never Married 2 🔯 Mem 3 ☐ Widowed 4 ☐ Divorced		2 No			2j⊈ No		Hican, etc.)		Bleck, White, etc.  Specify: White		
2	72 ho	ted	15. Deceden	t's Education		16e.	Decedent's U	uel Occu	pation during most of worked)	rin a	16b. Kind of B	usiness/Inc	lustry	
N	and and a	npie	(Specify only highest Elementery/Secondery (0-12)	College (1	1-4or 5+)								1 0	
7	12 should be filed within h and Mental Hyglene. Is marked other than " raumatic event, the Mes	Completed	8			0	wner/op	perat	T		Hagersto		duce Car	mpany
ב	d defined by the first	Be	17. Fether's Neme (First, Middle,	•					18. Mother's Nem	's Neme (First, Middle, Meiden Surneme) Zinkand				
Š	d 2 should th and Mer 7 is marke traumatic	2	Samuel Ray G											
<u> </u>	12 sh and is m		19e. Informent's Neme/Reletions						t and Number or Rui					01 705
	of Heelth is itam 27 is other tra		Helen L. Gles 20a. Method of Disposition	sner	Wife		18 Vir		a Avenue		msport,			21.795
ō	Peges net: If its iry or of		1 ☑ Burial 2 ☐ Cremetion	3 Removel from		cemeter	y, cremetory o	r other ple	ece)	Dete	20c. Location - City or Town, Stete			
Baltimore,	timent:		4 Donetion 5 Other (S		Ro	se I	Hill Ce		7	1/2/99	Hagerst	cown,	Maryl	and
g	permit. Peges Depertment of Important: If it any injury or once.		21. Signature of Funerei Service	Licensee	120				ess of Fecility Minnich	305 N	Potoma	ac St	reet	
	70 = 6 Q	-	Duedo.	Inm	nen		Funer	al H	ome	Hagers	town. I			740
,	Physician		23a. Pert1. Enter the disease, or shock, or heart feilure. List	complications that conly one cause on e	eaused the dee each line.	th. Don	ot enter the m	ode of dy	ing, such es cardiec	or respiretory err	est,		Approximet Intervel Bet Onset end I	te ween
	/Medical Examiner	ш	Immediate Couse (Finel disease or condition resulting in deeth)  Severe Chronic Obstructive Pulmonary Disease  Due to (or es e consequence of):										years	,
Е	LAdillilei	l.												
	ed sit	lie		and I	REspira	tory	Failu	re				1	years	•
x 68/60,	entificate be axecuted fing physician end se as the burial-transit	Medical Examiner	Ceuse (Diseese or Injury thet initiated events Due to (or es a consequence of):											
O. Box	the attending	Physician/M	Pert II. Other significant condition	d	sath but not re	sulting in	the underlying	cause g	iven in Pert I.	23b. Did tobacco use contribute to the cause of de				of death?
7	that the de led by the a detached t		History Blade	der Cancer	r					1 K)X	es 2 No	3 Prot	bebly 4	Unknow
Hecords,	ew requires is been sign 2 should be	Completed by								24e. Wes e perfor		eve	ere eutopsy f eilable prior t mpletion of d deeth?	to
r	The laste he	6								1 □ Y	es 210 No	10	Yes 2	No
Vital		Be	25. Wes case referred to medical examiner?						26. Piece of Deel	th (Check only or	те)			
0	G is	2	1 ☐ Yes 2 No	Hospitel: 1 🔀 I	Inpatient 2	] ER/Out	patient 3	DOA O	ther: 4 Nursing Ho	ome 5 Reside	ence 6 □Oth	er (Specif)	y)	
פוסוי	orie une		27. Manner of Deeth  1 Neturel 5 Pendin 2 Accident Investig	etion	of Injury th, Day Year)	28b. T	ime of njury M	28c. Inju Wo	ury et ork? ] Yes 2 □ No	28d. Describe h	ow injury occur	Ted		
Division	af or Attend s eftar death i Director: A ed in by the f	Certification:	3 Suicide 6 Could in determine	ined 200. Placa	of Injury - At t ng, etc. (Speci	iome, fer	m, street, fect	ory, office		28f. Location (S City or Town		ber or Rura	l Route Num	nber,
	To the Hospital or A within 24 hours eftar To the Funeral Director Completely filled in b	edicai (	29a. Certifier (Check only one) 1 Certifyin 2 Madical	Examiner: On the ba	best of my kno asis of examine ner steted.	owledge, etion end	deeth occurre Vor Investigati	ed at the ton, in my	ime, dete end plece, opinion, deeth occur	end due to the c red et the time, d	ause(s) and make end plece,	enner es st and due to	eted. the cause(s	s)
	Withir To th	M	29b. Signature and this of certifie				2	9c. Licen	se number	2	9d. Dete signe	d (Month,	Dey, Year)	
1			Short	W. Dir	(1,-			1	DO1062	0	ctober	29	1999	
			30. Neme end eddress of person		e of deeth (ite	m-23a) (	Type, Print)		-0.00	10	CCODCI	,		
			Edward W. Ditte					hing	ton St. I	Hagersto	wn, MD	217	740	
	Sta	ite	31. Dete filed (Month, Dey, Year)	32. R	gistrer's Sign		G. A.							
	Registr	ar	NOV 01	1999		/	J. P.	OOLA	2/					

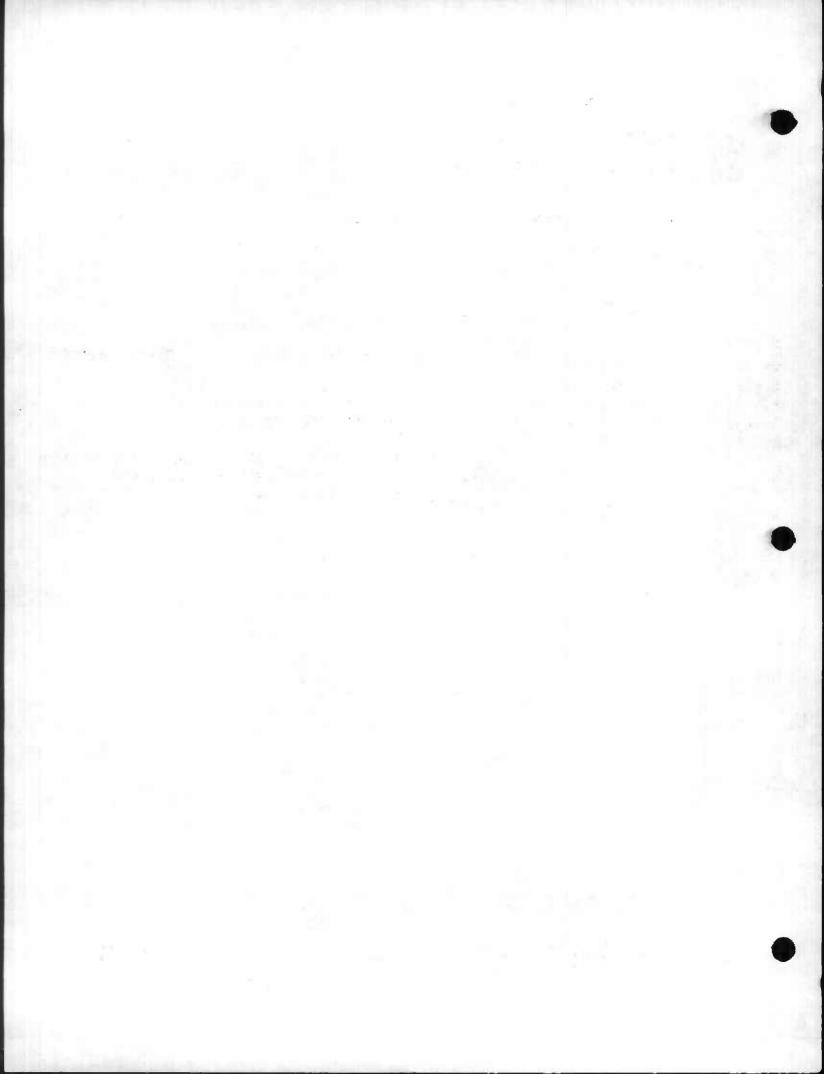


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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** Elizabeth Jane GREENLEE 2:25 Pm November 1990 /Medical 4c. County of Death 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown ff Under 1 Yaer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 1□M 2Ā F 59 Yrs. 220-42-3518 Director Sept. 24,1940 Maryland Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f show 1X Yas 2 □ No Director Maryland Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 2 23 Main Street 238 21722 USA Funeral death Rema 12. Was Decadant Evar in U,S Armad Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Maritel Status permit. Peges 1 end 2 should be filed within 72 hours effer. Department of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or ther any injury or other traumatic avent. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: þ white 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 10 ribbon company quality control 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maiden Sumama) Be Thomas S. Johnson Evelyn Mullin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) John R. Greenlee - son P. O. Box 574, Clear Spring, Md. 21722 20b. Place of Disposition (Name of cematery, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Crametion 3 ☐ Removal from Stata 11-4-99 Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland perme and Addrass of Facility MINNICH FUNERAL HOME 21. Signature of Funerat Service Licenses 15 E. Wilson Blvd., Hagerstown, Md. 21740 234. Part1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examine Examiner the buriel-trensit Sequantially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Cause (Disaasa or injury thet initiated evants rasulting in daath) Last Dua to (of es e consequence of): Physician/Medicai Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 2 No 3€ Probably 4 Unknown ete hes been signed page 2 should be de by Records, 24b. Wara autopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Was an autopsy 10 Yas 2 □ No 1 ☐ Yas 2 ☐ No certificete Division of Vital or Attanding Physician: 25. Was cese rafarred to medicel 26. Place of Deeth (Check only one) Hospital: 1 2 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Mennef of Death 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No within 24 hours after deeth. To the Funeral Director: A invastigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, straet, fectory, office building, atc. (Specify) 20 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to tha ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, data end place, and due to the cause(s) and manner mad. edicai 29a. Certifier ş 29d. Data signed (Month, Day, Year) 29b. Signature end titla of certifiar 29c License number and addrass of person who complated ceuse of death (Item 23a) (Type, Print) 110 has 31. Dete filed (Month, Dey, Year) NOV 0 3 1999 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

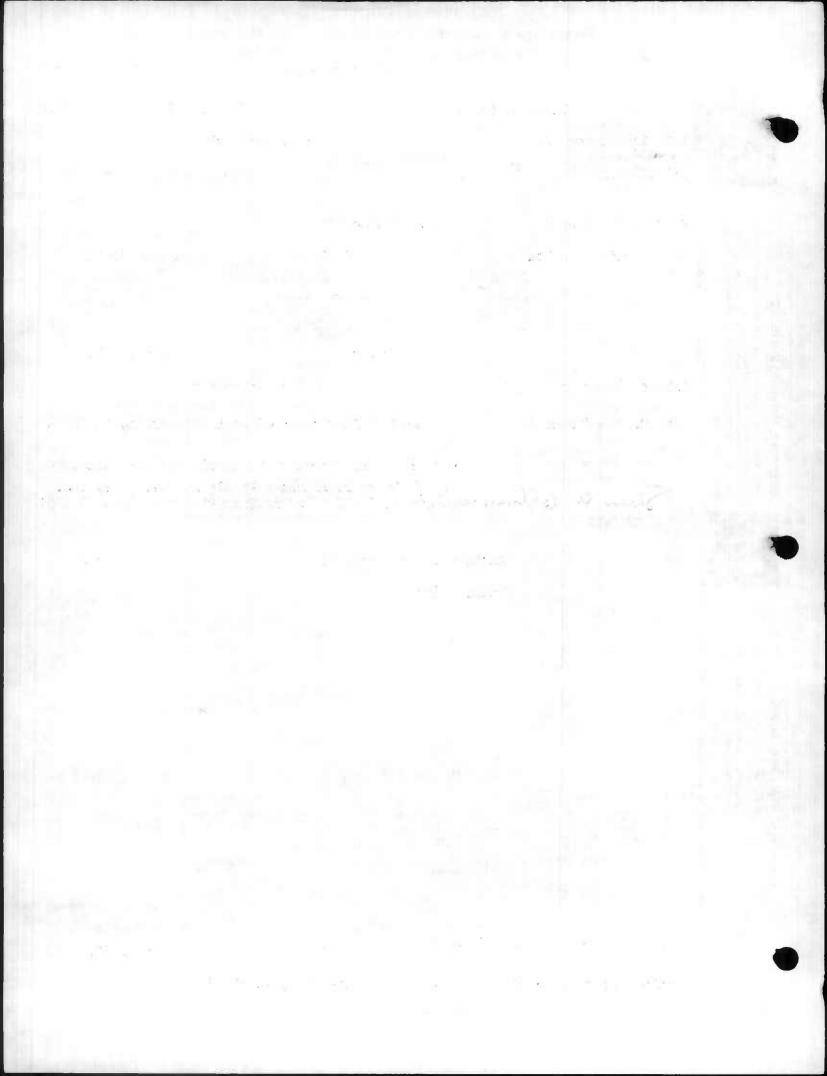
Registrar



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State of Maryland / Department of Health and Mental Hygiene

36486 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** October 26 1999 4:30am Gladys Marie Gray /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3000 Pfefferkorn Road West Friendship Howard 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 210 F Months Deys Hours Yrs. 216-07-4022 85 Sept 6, 1914 Maryland Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10e Stete 10h County 10c. City. Town or Location r 28a-f show show 1 ☐ Yes 2 No Directo Maryland Howard West Friendship 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or flems 23a or traumatic event, the Modical Examiner must be 3000 Pfefferkorn Road 21794 United States Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus nit. Pages 1 end 2 should be filed within 72 hours after or serment of Health and Mentel hygiane. ortant: If Item 27 Is marked other than "natural", or fier Injury or other traumatic event, the Medical Examine. 1 Never Married 20X Married Maryland 21215-0020 1 Yes 2 No Specify: Specify. g 3 Widowed 4 Divorcad White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Cotton Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Arthur Vipperman Elsie Schneider 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Earl M. Gray/Husband 3000 Pfefferkorn Road West Friendship, MD 21794 Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Good Shepherd Cemetery 10-29-99 Ellicott City, MD 21. Signature of Funerel Service Licansee 22. Name end Address of Feelility Harry H. Witzke's Family Funeral Home, Inc. C OC 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Cerebrovascular Accident Acute Examiner Due to (or es e consequence of): Examiner Hypertension physician end s the burief-transit the death certificete be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760. Physician/Medicai Due to (or as a consequence of): 88 esn 0 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy Completed page 2 has 1 Tyes 2 No 1 TYes 2 TNo certificata Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔯 Residenca 6 ☐ Other (Specify) 0 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After Injury 1 Neturel 5 Pending after death. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide filled in 24 hours 29e. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. edicai completely (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. To the within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D25947 October 26, 1999 V 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Evelyn Jackson, MD 5540 Ten Oaks Road Clarksville, MD 21029 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State OCT 2 6 1999 > south Registrar



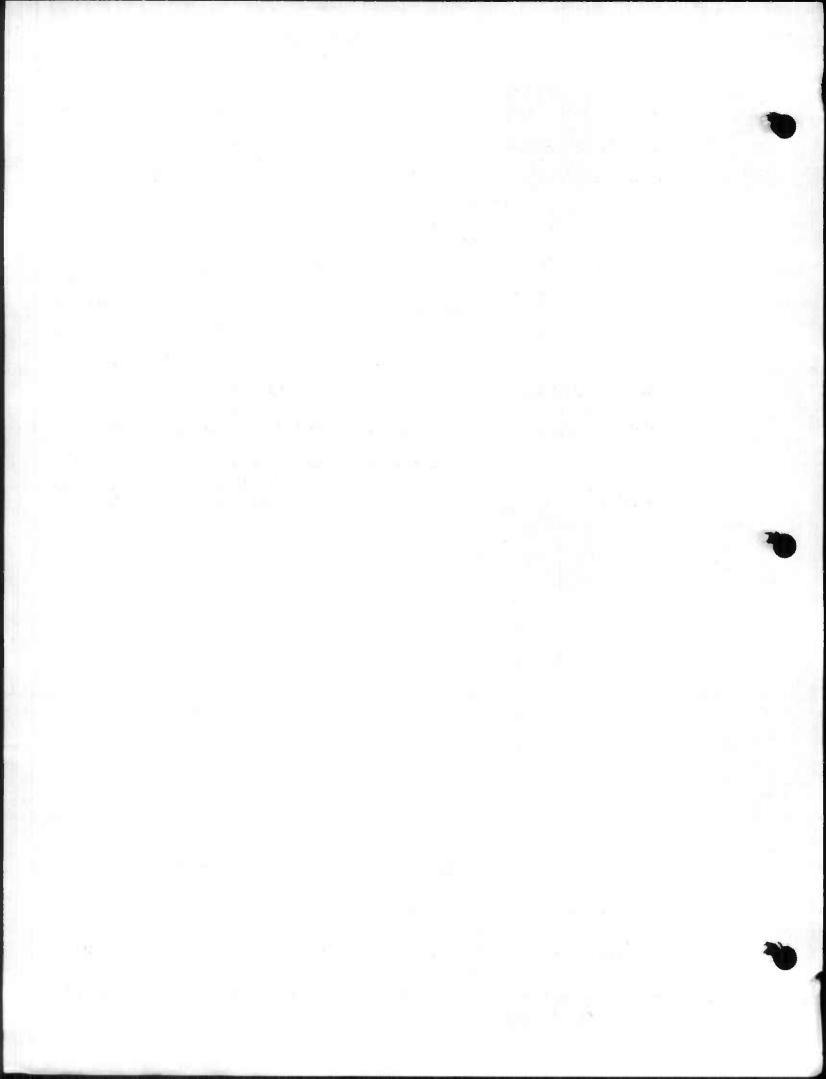
State of Maryland / Department of Health and Mental Hygiene

36487 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth Month **Physician** November 1, 1999 Thurston Eugene Grim 11:15 PM /Medical 4a. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2221 Dargan Road Sharpsburg Washington | If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 24 Hrs. | 1 Under 2 5. Sociei Security Number 7. Aga (In yrs. last birthdey) Birthplece (Steta or Foraign Country) **Funeral** Months 1 MM 2□ F Yrs 69 Director 236-62-0532 1930 Maryland Usuei Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any hijury or other traumatic event, the Medical Exercise. 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☑ No Director Md. Washington Sharpsburg 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Coda 2221 Dargan Road Funerai 21782 USA 12. Was Decedent Ever in U,S. Armed Forces? Race - Amarican Indien, Bieck, Whita, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 11. Maritai Status 1 X Yas 2 No If Yes, Give Yaar or Datas: 1948-1968 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Soldier U. S. Army 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middla, Meidan Surnama) Be Marvin Arthur Grim Sarah McGowan 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Amelia A. Grim, Wife 2221 Dargan Road - Sharpsburg, MD 21782 20b. Piece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremetion 3 Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) Samples Manor Cemetery 11/4/99 Sharpsburg, MD 21. Signature of Funarel Service Licansee 22. Name end Address of Fecility Eackles-Spencer Funeral Home Harpers Ferr

23e. Pert1. Enter the disaasa, or confidications thet causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. Harpers Ferry, WV 25425 Approximate Onset and Deeth **Physician** Immediate Ceuse (Final disaase or condition resulting in deeth) /Medical CARCINOMA OF THE LUNG 2 YRS. Examiner Due to (or es a consequence of): Physician/Medical Examiner ettending physician end for use as the buriel-transit The law requires that the death certificeta be axecuted Sequantially list conditions, if any, leading to Immediata ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown þ been si 24b. Wera autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica 25. Wes cese referred to medicel examiner? Be 26. Pieca of Daeth (Check only ona) Hospitel: 1 inpatient 2 ER/Outpetlent 3 DOA Other: 4 ☐ Nursing Home 5 ☒ Residance 6 ☐ Othar (Specify) Certification: To 1⊠Yas 2□ No 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Neturai 2 Accident 1 Yes 2 No 6 Could not be determined within 24 hours after der To the Funeral Director completely filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the causa(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) chuca W Di Hos D01062 November 5, 1999 30. Neme end eddress of person who complated cause of deeth (Item 23e) (Type, Print) Edward W. Ditto, III. M. D. - 217 W. Washington Street - Hagerstown, MD 21740 Data filed (Month, Day, Yeer) 32. Registrary Signature 132. Registrary Signature 132. Registrary Signature 132. Registrary Signature 133. Registrary Signature 134. Registrary 31. Data filed (Month, Day, Yeer) 0 8 1999 State B. Spork.

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) **Physician** Hilda /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 210 F Days Hours 220-76-3413 Director Usual Rasidence of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or itema 23a or 28a-1 show injury or other traumatic evant, the Medical Examiner must be notified at Director Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 21802 Snowhill Road 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Dates: 11. Marital Status Navar Married 2 Married 1 ☐ Yas 2 No Specify: by 3 Widowad 4 Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) filed within 7 Hygiana. pemit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If Item 27 is merked other than any injury or other traumetic avant Elementery/Secondary (0-12)

College (1-4or 5+)

1 ☐ Yas X☐ No 10g. Citizan of Whet Country? USA Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amarlcen Indian, Black White etc. Specify: Black. 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry None None

18. Mothar's Nama (First, Middla, Maidan Sumame)

2. Date of Death

8. Date of Birth (Month, Day, Yaar) 11-29-1941

October 30, 1999

4c. County of Death

WICOMICO

Md.

Birthplaca (State or Foraign Country)

10d. Inside City Limits

Month

Bennett E. Giles 19a. Informant's Name/Relationship (Type, Print)

17. Fathar's Nama (First, Middla, Last)

Florence Banks 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

Robert Giles, Brother 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Spacify)

20b. Placa of Disposition (Nama of cematary, cramatory or other place) Cambridge Crematory

20c. Location - City or Town, State 11-2-99 Cambridge, Md.

21. Signature of Funaral Sarvice Licensae

22. Nama and Addrass of Facility Short Funeral Home, Inc. 700 W. St. Laurel, De. 19956

512 Haverford Drive, Columbus, Ga.

23a. Par1. Entar the disaase, or complications that caused the death shock, or haart failura. List only ona cause on each lina.

not antar the mode of dylng, such as cardiac or respiratory arrast,

Approximate Intarval Batween Onset and Deeth

Immedieta Causa (Final disaasa or condition rasulting in daath)

Mustured, perforated Colon -Due to (or as a consequence of):

Dua to (or as a consequence of)

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarfying Causa (Disease or injury that initiated events resulting in daath) Last

art II. Other afgnificant conditions con	tributing to death but not rasulting In tha undarlying causa givan in Part
0	

23b. Did tobacco use contribute to the cause of death?

Severe mental retardation, long term institutions Severe Choric Constrpition

alion 2000 3 Probably 4 Unknown 4a. Was an autopsy performed?

24b. Wara autopsy findings availabla prior to complation of ceuse of death? 1 Tyas 2 No

25. Was casa refarred to medicel 1 Yas 2 No

Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA 28b. Time of

26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28c. Injury at Work?

Naturel 5 Pending invastigation 2 Accidant 6 Could not be determined 3 Sulcida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Dascribe how Injury occurred 1 Yas 2 No

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar

27. Mannar of Death

4 Homicida

🖄 Certifying Phyafcian: To the best of my knowladga, daath occurred at tha tima, data and place, and dua to the ceusa(s) and mannar as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. 29c. Licansa numbar

29b. Signature and title of certifier · Koutenberg

15857

29d. Data signed (Month, Dey, Yaer)

2 State Registrar

**Physician** /Medical

Examiner

signed by t d be detach

page 2

certificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; s

Physician/Medical

Completed

Be

P

Certification:

Medicai

P.O. Box 68760,

Records,

Division of Vital

30. Name and addrass of person who completed dausa of death (Itam 23a) (Type, Print)

Dr. Johy Routenburg 205 S. Division Street Salisburg Md. 2180/ 31. Data filed (Month, Day, Year) NOV 02 1999 32. Redstrars Signatura G. Sports

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death GLENNA Dey HAJEK **Physician** NOVEMBER 6, 1999 11:40 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Good Samaritan Hospital If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Months Days Hours 1□M 2☑F 63 Director 214-34-0626 Dec. 5, 1935 Usual Residence of Decedent 10a. Stete 10b Counts 10c City Town or Location 10d. Inside City Limits 28a-f show Baltimore Maryland Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 1801 Wentworth Road U.S.A. Items 23s 14. Raca - American Indien, Black, White, etc. 11 Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pegas 1 and 2 should be filed within 72 hours after c Department of Heelih and Mentel Hygiena. Important: If item 27 is marked other than "natural". or heavy injury or other treumatic event 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married white 1 Yes 2 No Specific p 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-12 College (1-4or 5+) chief clerk correctional 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Ketterman Hubert C. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Colonial Court, Littlestown, Pennsylvania 17340 Mr. Bradley Hajek/son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Nov. 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 11,1999 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 red IN estat 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** SEPTIC SHOCK.

Due to (or as a consequence of):

URDSEPSIS

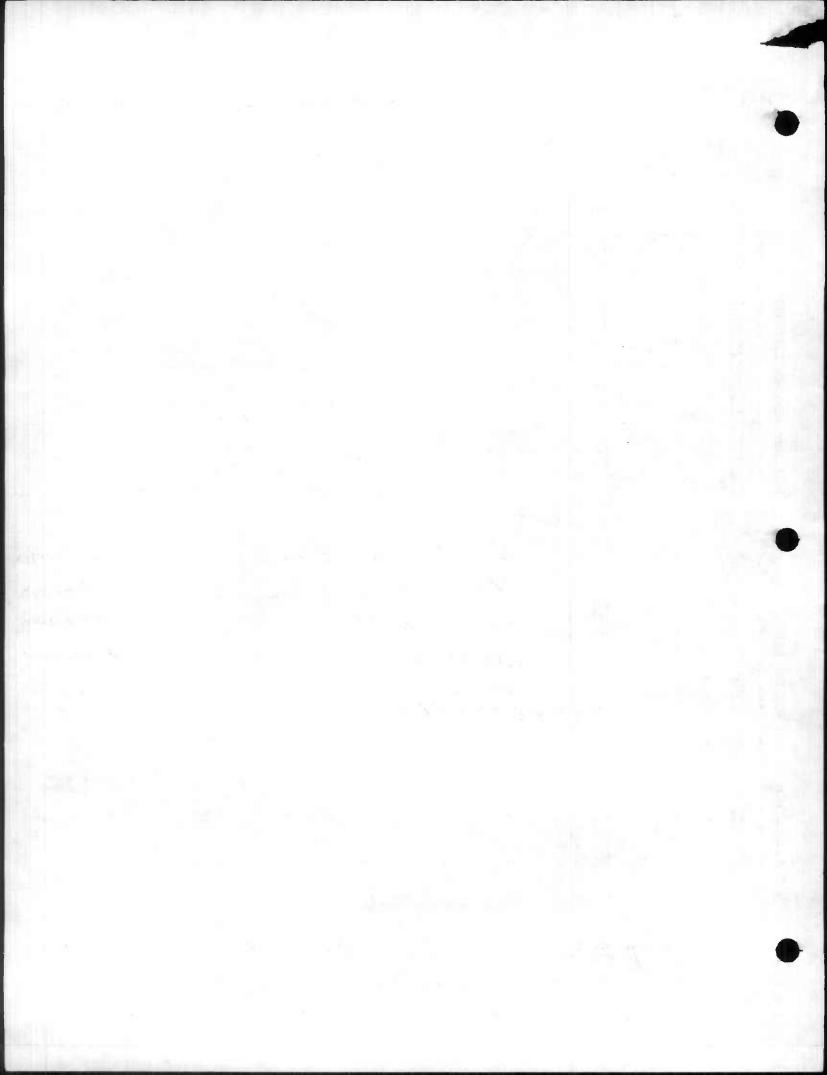
Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) <24hrs Examiner UNKNOWN physicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest PNEUMONTA.

Due to (or es a consequence of): UNKNOWN Box 68760. Physician/Medicai UNKNOWN Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. D.0 23b. Did tobacco use contribute to the cause of death? PNEUMOTHERAX 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy 1□ Yes 2⊞No 1 ☐ Yes 2 ☐ NO Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Pres 2 No 2 142 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certification: 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturat 5 Pending investigation n 24 hours after death.

Ne Funerei Director: Afte pletely filled in by the fun 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) P-11389 NOVEMBER 6, 1999. 30. Nome and address fol person who completed cause of death (Hern 23a) (Type, Print)

BIUSGRT BOOKHSI, 6935 DONACHIE ROLATO, BALTIMORE-MD

21239. 32. Redistrar's Signature State NOV 0 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death NOVEMBER 1999 EARL JACOB HEGE 1:05PM 4e. Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death National institute of Health Bethesda Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sax YEM 2□ F 7. Age (in yrs. last birthdey) Birthplace (State or Foreign
Country) Deys Months 48 164-46-6911 Nov. 23, 1950 Virginia Usual Rasidence of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Pa. Franklin Chambersburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 17201 USA 3966 Funk Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Reca - American Indian, 11. Maritei Stetus Black, White, atc. 1 Nevar Married 2 Married 1 □ Yas 2 □ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Agriculture Farmer 8+ 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Surname) Catherine Heatwole Paul Hege 19e. informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Hege/wife 3966 Funk Rd., Chambersburg, Pa. 17201 20a. Method of Disposition
1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramovel from Stete 20b. Piece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stata Culbertson Cemetery Nov. 5 Chambersburg, Pa. 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Facility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd.N, Hagerstown, Approximete interval Batween Onsat and Deeth seesa, or complications thet causad tha daath. Do not enter tha moda of dying, such as cardiac or respiratory errest, ura. List only one ceuse on aach line. Immediata Ceusa (Final disease or condition rasulting in deeth) Pulmonary Dua to (or Tumor Thrombus Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseesa or injury thet initieted evants rasulting in death) Last Dua to (or es e consequanca of): Pert Ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes ANO 3 Probably 4 Unknown mona 24b. Wara autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy 2/ No 1 Tyes 1 ☐ Yas 2 No 25. Was case referred to medical 28. Piece of Deeth (Check only one) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred Naturai 2 Accidant 5 Panding invastigation NA 1 Yas 2 No 6 Could not be datermined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicida 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide N-A Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete and piaca, and dua to the causa(s) and menner as steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred at tha time, date and piace, and dua to the causa(s) and mannar stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. Licensa number 29d. Data signed (Month, Day, Year) and addrass of person who completed causa of death (itam 23a) (Type, Print) REDRICK 5

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiene. Important: if itsm 27 is marked other than "naturel", or her any injury or other traumatic event, the Medical Examines once.

Physician

/Medical

Examiner

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signed by the e

certificate hes b lirector, page 2 s

this funeral

After

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• Funeral Director: Aipletely filled in by the fu

To the Hosp within 24 ho To the Fune completely fi

The lew requires that the deeth certificate be executed

or Attending Physicien:

r deeth.

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner

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Completed

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Certification:

Medical

Director

Funeral

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Completed

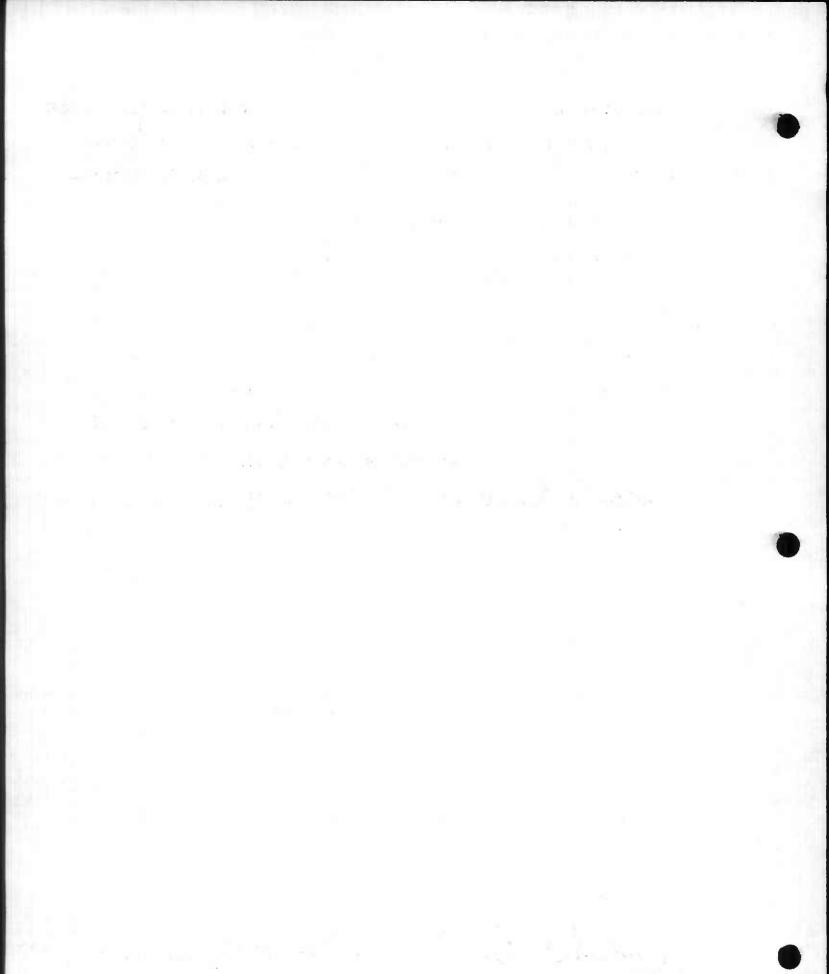
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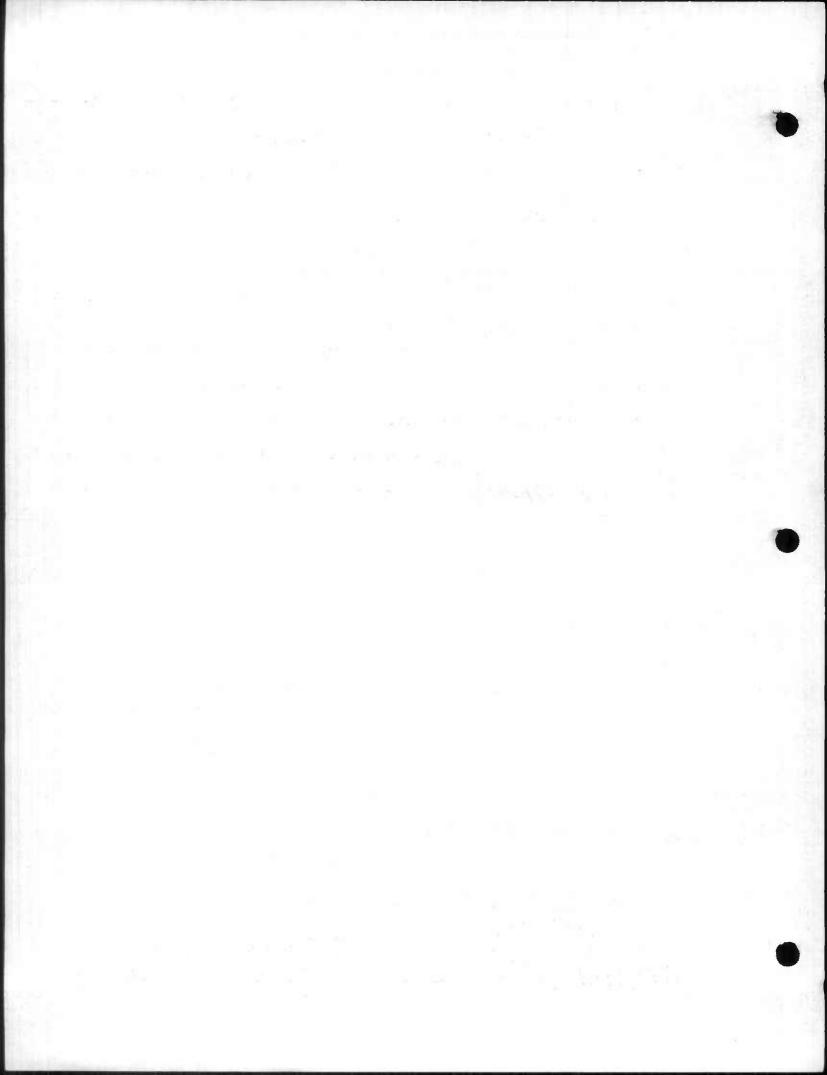
31. Data filad (Month, Day, Year) NOV 0 4 1999

EACH 32. Registrar's Signetura come

9000 ROCKVILLE PIKE, BETHESDA, MD 20892



			State of M	aryland /		rtment of I tificate of		d Mental Hy	giene !	99	36491
	1. Decedant's Nama (First, Middle, Last) Physician Medical Helen Rebecca Holsinger			inger				Octobe	2. Data of Daeth October 31, 199		3. Time of Death 5:45 a.m.
Exami		ner	4e. Fecility Nema (If not institution, give street end number) Homewood Retirement Cente				4b. City, Town, Willia	or Location of Deat MSDORT		ty of Death	
	Funeral Director	Г	215-20-8106 1 <sup>1</sup> M 27 F 90	ge (In yrs. last b	virthday) Yrs.	If Undar 1 Yaar Months Days	if Under 24 Hours	Hrs. 8. Data of Bi (Month, Do Octobe	rth ey, Year) er 1, 19	9. Birth	piace (State or Foreign intry) ennsylvania
Z 2 8	76 2	To Be Completed by Funeral Director	17. Fathar's Nama (First, Middle, Last)	No 166 5+) 19 San 1	13. William Deceding Medition 1905. Mailing 17903	106. Zip Coda 21767  Ves Decedent of If Yes, specify Cub  Yes, specify Cub  Yes, 2 No ent's Usuei Occupind of work done of NOT use retire at cutte	an, Maxicen, P Specify:  Deation during most of d)  18. Mothar's Nellie and Number of	working  Nema (First, Middle  Grace Ba r Rural Route Numb	16b. Kind of I Holsinge , Maiden Suma	is Whet Countries - Americae - Am	white Industry  at Market  Ip Code)  and 21740
Baldmore,	bemit. Pages 1 and Department of Healt Department of Healt Important: If Item 23 important: If Item 23 important: If Item 20 important of other 10 important of other 10 important of other 10 important impor		1 Buriel 2 Cramation 3 Removel from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  2 Pert1. Enter the disease, or complications that cause shock, or haart failura. List only ona cause on each limmediata Causa (Final disease or condition rasulting in deeth)	Rest I	Haver 22. Ge F1 o not ente		ry  ess of Fecility  Minnic  ome	h 305 N	. Potom	nac St	Maryland treet land 21740 Approximete intarvai Batween Onset and Death
VICAL MECONGS, P.O. BOX Of Iclan: The law requires that the death certific and filters has been stoned by the attending	h certificate be executed ending physician and ruse as the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, laading to Immadiate cause. Entar Undarlying Causa (Disaase or injury that initiated events resulting in daeth) Last  d.	Dua to (or es e				ы			
	The law requires that the ate has been signed by the page 2 should be detach	Medical Certification: To Be Completed by Physician/M	Pert ii. Other significant conditions contributing to death by the conditions contributing to death by the conditions contributing to death by the conditions of the conditions are contributing to death by the conditions of the c	ent 2 ER/O ry y Year) 28b. ury - At homa, 1 c. (Specify) of my knowledge f examination ai	Outpatient Tima of injury farm, stree	3 DOA Oth  28c. Inju  Wo  At factory, office	26. Place of nar: Nursing at the? I Yas 2 No	24a. Wesperfi	Yes 2 No s an autopsy ormed?  Yes 2 No one) idance 6 O how injury occur (Street and Num wn, State)	3 Production of	ral Route Number, steted. to tha cause(s)
	Sta Registr			laath (item 23a)	G.	Print) free	14905	Your	111	20	245



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month Anna Kathryn HILL OCTOBER 31, 1999 /Medical 10:25 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 24 Hrs. If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Min. Days Hours Months 1 M 2 XF 79 Nov. 11 1919 Director 213-18-8406 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1Ñ Yes 2□ No Director or 28a-f Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 21740 U.S.A. Funeral 1183 Luther Drive 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Her Own Home 12 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event B 2 Maude Clark Raymond Purnell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Donna M. Wieland - Daughter 16619 Johnson Drive Williamsport, Maryland 21795 ace of Disposition (Name of Dete 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/3/99 | Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral-Service Licensee 115 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such es cardiac or respiratory errest, Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Final larkresones disease or condition resulting in death) Examiner neamouna physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of) 100 00 d Box ( signed by the eld by the eld by Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? pege 2 should Completed 24a. Was an autopsy 1 Yes 22 No 1 ☐ Yes 3 € No certificete VItai To the Hospital or Attending Physicien: within 24 hours ster deeth.

To the Funerel Director: After this certifica completely illied in by the funeral director. 25. Was case referred to medicat examiner? B 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA of 27. Mapner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Division 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death/(Hem 23a) (Type, Print) Hegiston MD2174a. 368 SHAFT Mell ST

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

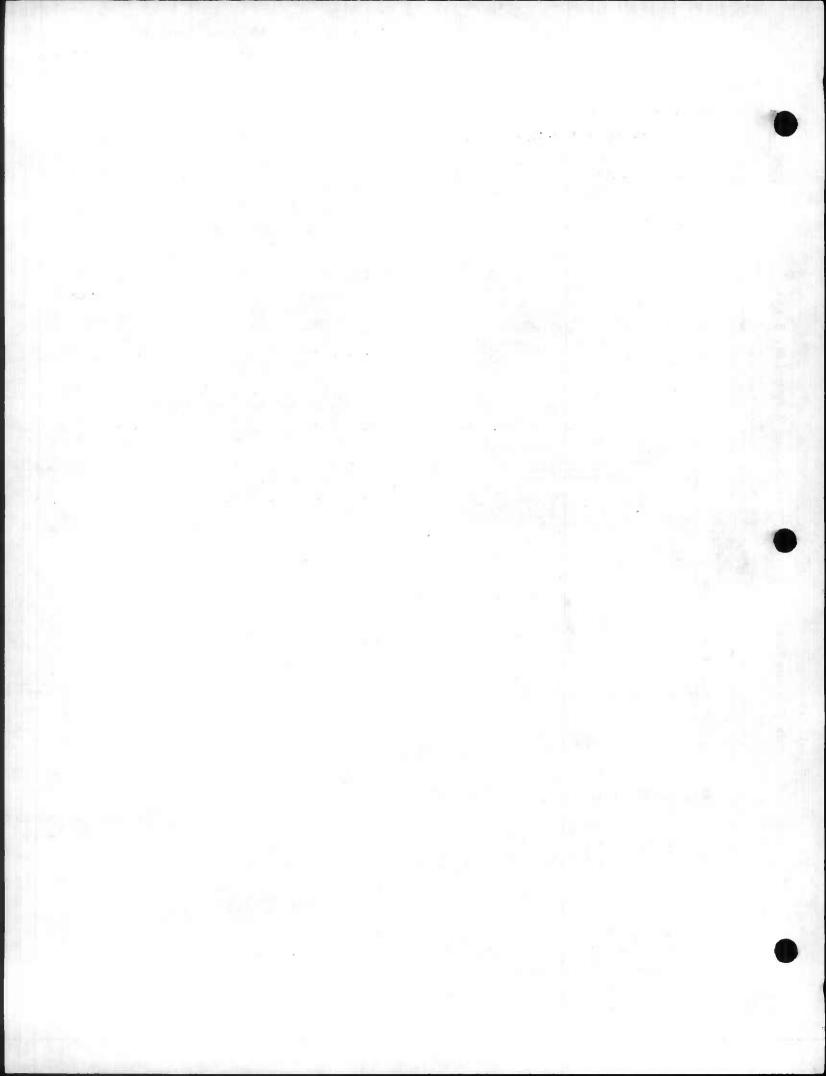
NOV 0 2 1999

Kathryn

Anna

32. Redistrar's Signature

Denew

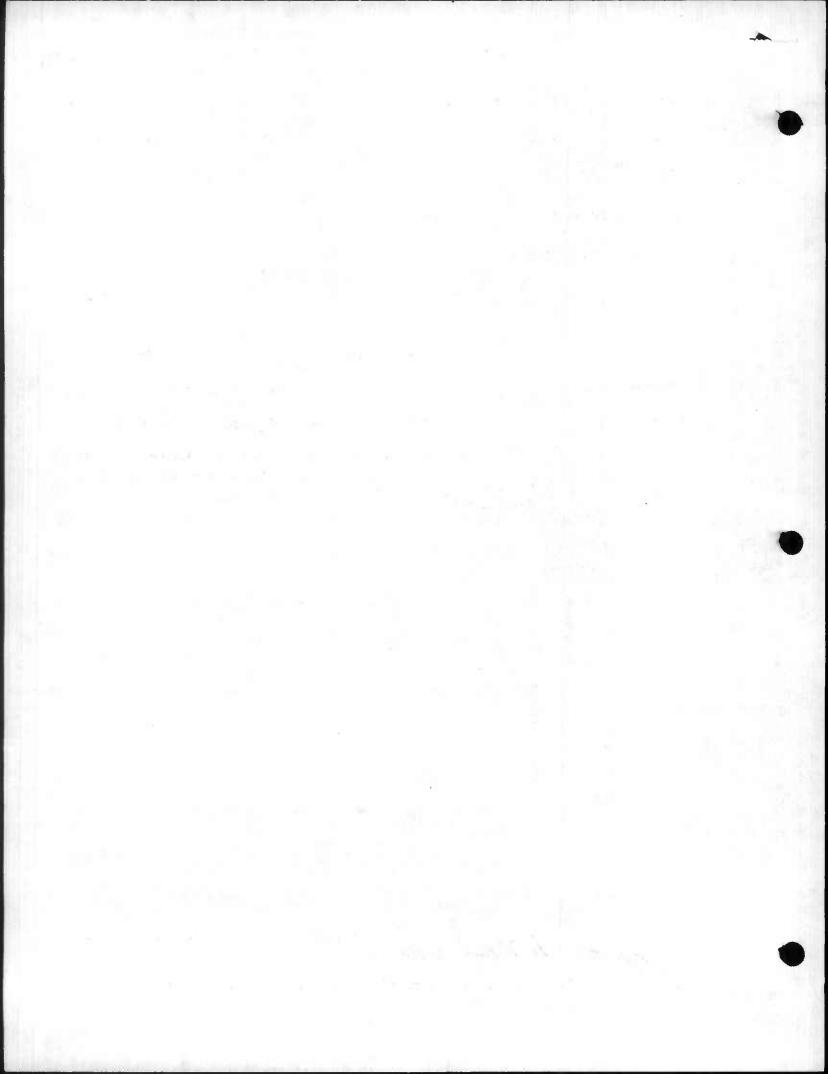


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended State of Maryland / Department of Health and Mental Hygiene Q Line 5. SC WCHD Certificate of Death 11-10-99 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** ELMER CLEVELAND HULL, SR NOVEMBER 6,1999 0645 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth University of Maryland Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 356 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Months Yrs. Director May 4, 1922 Waynesboro, PA Usuel Residence of Decedent with the Meryland 10e. Stete 10b. County in than "netural", or items 23e or 28a-f show 10c. City, Town or Location 10d. Inside City Limits PA Franklin Waynesboro Director XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 237 West Second Street 17268 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 ™ Yes ≥ □ No If Yes, Give Yeer or Detes: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. of filed within 72 hours after if Hygiene.

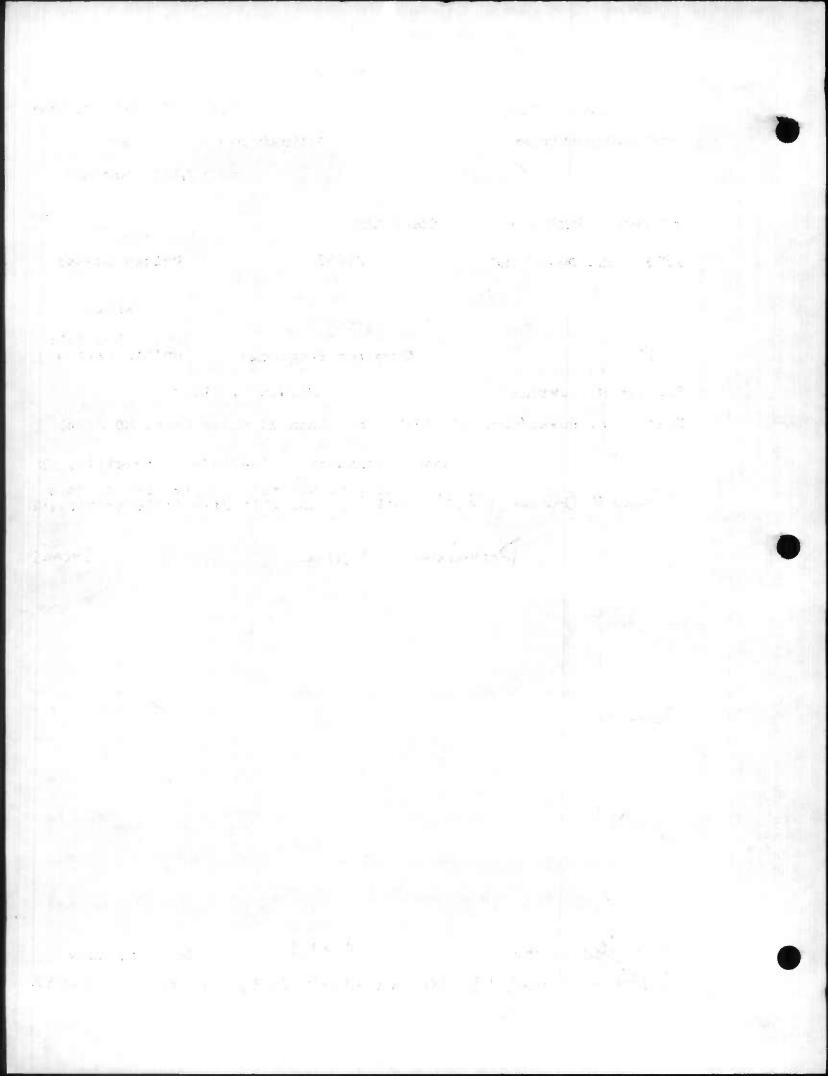
Other than "netural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: p Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 11 Salesperson Freight Co permit. Peges 1 and 2 should be file Department of Heelin and Mentel Hy Important: if Item 27 is marked other any injury or other trauments event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover C. Hull Ella Rosetta Shives 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Marie Hull 237 W Second ST Waynesboro PA 17268 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 X Removal from State Green Hill Cemetery Nov 10 Waynesboro 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Grove Funeral Home, 22. Name end Address of Facility 50 S Broad ST Waynesboro PA ames pullso 23e. Pert Enter the disease, or complications that caused the shork, or heart failure. List only one cause on each line. deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, Approximete Interval Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Ruptured Abdominal Aortic Aneurysm 90 minutes Examiner Due to (or es e consequence of) attending physiclan end for use es the buriel-transit The law requires that the death certificete be executed Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es e consequence of): Box 68760 Physician/Medical thet initiated events resulting In death) Lest Due to (or es a consequence of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed b Records, δ 24b. Were eutopsy findings aveilable prior to Completed 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred s effer dea... 1 K Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital o within 24 hours of To the Funeral D completely filled i 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner steted. edicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) P 09796 November 6, 1999 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) ) 22 S. Greene
32. Roughrar's Signature Cynthia D. Nelms, MD Baltimore 21210 State Docks Registrar



State of Maryland / Department of Health and Mental Hygiene 00

			Certificate of	Death	Re	eg. No.	3 3	6494		
	1. Decedent's Name (First, Middle, Last	9			2. Date of Deat Month	h Dev	Year	3. Time of Death		
Physician Medical	Mary V.	Howes			October		999	12:15pm		
Examiner	4a Fecility Name (If not institution, give			4b. City, Town, or L	ocation of Deeth	4c. County	of Death			
	10093 Maplewood Di	rive		Ellicott	4	Howard				
Funeral Director	5/8-20-8463	7. Age (In yrs.	Yrs. If Under 1 Yea Months Days		8. Date of Birth (Month, Dey, March	Year) 2,1921	9. Birthpla Country Mary.			
pue M.	Usual Residence of Decedent  10a. State 10b. County	10c. Cř	ty, Town or Location				100	d. Inside City Limits		
Maryl f sho	Marril and Wareh	aghau	Ocean City					1 ☐ Yes 2X No		
the 128s	Maryland Worche	secer	Ocean City		10	0g. Citizen of V	Vhai Countr	v?		
Jufer death with the Mainter death with the Mainter 23a or 25a-fs direct must be nuclead. Funeral Director	10706 6 1 7		2184	10		77 . 2 1	1 01			
The 2	13706 Sand Dune	12. Was Decedent Ever in U			ecify Yes or No-		e - Americer	n Indian,		
Datifillore, Marylatina ZIZ 13-0020  Demit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Haalth and Mantel Hygiane. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important in the Configuration of the Configur		Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give		nt of Hispenic Origin? (Specify Yes or N y Cuban, Mexicen, Puerto Rican, etc.)			k, White, et	c.		
by Brit.	3 ☐ Widowed 4 ☐ Divorcad	If Yes, Give ** Year or Dates:	1 ☐ Yes 2 ☐XNo	Specify:		Specify	Specify: White			
l XIX IO-UOZO led within 72 hours ef tygiene. rer than "natural", or nt, the Medical Exam t, the Medical Exam Completed by §	15. Decedent's Edu		16a. Decedent's Usuai Occu	upation	ring	16b. Kind of Business/I				
within ane. than "r	(Specify only highest gred Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retir	ed)		Social				
of the vithing the filed withing he filed withing the filed withing the filed within	12		Computer		Admini		tion			
Be doth	17. Father's Neme (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	<i>Maiden Surn</i> em	e)			
should be and Mantel or umarked o	Francis M. Hawl			Birdie						
Maryland of 2 should be file th and Mantel Hy to is marked othe traumatic event To Be (	19e. Informant's Name/Relationship (T)		19b. Mailing Address (Street							
Tand 1 and 1 Haalth em 27 in wither tr	Charles R. Howe		13706 Sand Place of Disposition (Neme of	Dune Rd		City,				
Dallimore, semit. Pages 1 ar Separtment of Has mportant: if Item in y injury or other ince.	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F		cemetery, cremetory or other pi	lece)	Date	20c. Location -	City or Tow	n, State		
Dentil Pages Department of important: if I any injury or DOGG.	4 ☐ Donetion 5 ☐ Other (Specify)		etro Cremato		0-26-99	Cator	svil	le, MD		
Demit. Permit. Popartme Importan any Injur	21. Signature of Funeral Service Licans	99	22. Name and Add	ress of Facility Witzke	c Fami	1 v Fur	oral	Homo		
40500	Show a Coll	his - Wigh	4112 010	Columb	ia Pike	Ellic	cott	City, MD		
	23a. Part1. Enter the diseese, or complishock, or heart failure. List only or	lications that caused the dear	th. Do not enter the mode of dy	ying, such as cardiac	or respiratory arre	est,		Approximate ntervel Between		
Physician		Onset and Death								
/Medical Examiner	Immediate Cause (Final disease or condition	· Parlan:	son's dise	all				3 YEARS		
	resulting in death)  Due to (or as a consequence of):									
si ed		b. ————					- 1			
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certificate be executed ding physicien end use as the burial-transit	that initiated events resulting in death) Lest Due to (or es e consequenca of):									
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eath cert ettendin for use			T. L. CA				1			
v requires that the death certifications is should be deteched for use eleted by Physician/M	Demenha					23b. Did tobacco use contribute to the cause of death				
that that the detail detail						1 ☐ Yes 2 ☑ No 3 ☐ Probably				
he law requires the law requires the law requires the law seen signer age 2 should be dompleted by						24a. Was an autopsy 24b. Were		e autopsy findings		
The law requir					perform		com	lable prior to pletion of ceuse		
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VIIdi nei iician: The lav certificata hes rector, page 2	05.186				1 T Ye	A	1	Yes 2□ No		
Physician: this certific ral director,	25. Was case referred to medical examiner?	Hospital:		Whor:	th (Check only on		40 41			
or Attending Physician: The affectors of the functor Affect this certificated in by the funeral director, posterification: To Be Coertification: To Be Coertification:	10 165 20 140	1 ☐ Inpatient 2 ☐	JER/Outpatient 3LI DOA	4 LI Nursing H	ome 50 Reside			-		
Attending in death.  Ctor: After by the funer iffication:	1 Natural 5 Pending 2 Accident investigation	(Month, Dey Year)	Injury W	ork? ☐ Yes 2 ☐ No						
Atten deal ctor: y the	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, factory, office	et. factory, office 28f. Location		on (Street and Number or Rural Route Number,				
tal or Attending P rs after death. al Director: After t led in by the funers Certification:	4 Homicide	4 Homicide building, etc. (Specify			City or Town	or Town, State)				
To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate hes complately filled in by the funeral director, page 2  Medical Certification: To Be Comp			owledge, death occurred at the ation and/or investigation, in my							
vithin outh ompl			29c. Lice	nse number	2	9d. Date signe	d (Month, D	ey, Year)		
F 5 F 0	) OM	12020						000		
10	30. Name and agoress of person who co	• 5		1011		Oct. 2	6, 1	999		
6	JOSEPH F. GIV	SAMC. MA		APOLIS AL	5	1051 (11	v. N	1 21042		
State	31. Dete filed (Month, Day, Year)	32. Registrar's Signa			1 ( )	11 (1)	11.	9 - 12		
Registrar		1000	eva la	books						
	0012	V . T . V	~ · ·	HURRY						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 2. Date of Deeth 8:00pm

**Physician** /Medical Examiner

**Funeral** 

Director the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinet must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit that the death certificate be axecuted 88 use ò signed by the a þ Completed page 2 s certificate Be 2 After this funerel Certification: 24 hours after deeth.

Funeral Director: A filled in by Medical complataly within 2

Division of Vital Records, P.O. Box 68760,

1. Decedant's Nama (First, Middle, Last) William A. Hylton November 1 1999 4a Fecility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death 5685 Harpers Farm Road Apt A Columbia If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 1916 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthdey) Birthplace (Stata or Foraign Country) M 2□ F Months Deys Hours 217-26-6320 83 Yrs. Virginia Usual Rasidance of Decedant 10a. Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits Directo Maryland Howard Columbia 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 5685 Harpers Farm Road Apt A 21044 United States Funerai 12. Was Dacadant Ever in U,S. Armed Forcas? 1 ☑Yas 2 ☐ No If Yas, Giva Yaar or Datas: WWII 14. Reca - American Indien, Black, Whita, atc. 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 □ Nevar Married 2 🖾 Married 1 Yas 2 XNo Specify: à 3 Widowed 4 Divorced White Completed 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Coilege (1-4or 5+) Elementary/Secondary (0-12) Cattle Broker Self Employed 18. Mothar's Nama (First, Middla, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Walter Hylton Susan Hurst 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 21201 19a. Informant's Name/Ralationship (Type, Print) William A. Hylton Jr./Son One Charles Center 100 N Charles St Ste 630 Balt MD 20b. Place of Disposition (Nema of camatary, cremetory or other place) 20a. Mathod of Disposition Deta 20c. Locetion - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11-2-99 Catonsville, MD 22. Nama and Addrass of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Sarvice Licensee 0-4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. immediate Ceuse (Finel disaasa or condition rasulting in death) 18YEARS & CHRONIC OBSTRUCTIVE PULMONARY DISEASE Dua to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaguance of): Physician/Medicai Due to (or es e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Nos 2 No

23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown BRONCHOGENIC CARCINOMA 24b. Were autopsy findings evailable prior to 24e. Wes en autopsy completion of ceuse of death? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was cesa referred to medical axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred 27. Mennar of Death 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 28b Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicide

(Check only one)

29a. Certifiar

1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and menner es steted. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signatura and titla of certifier BILLIMO 29c. Licensa number D0018317

29d. Date signed (Month, Dey, Year)

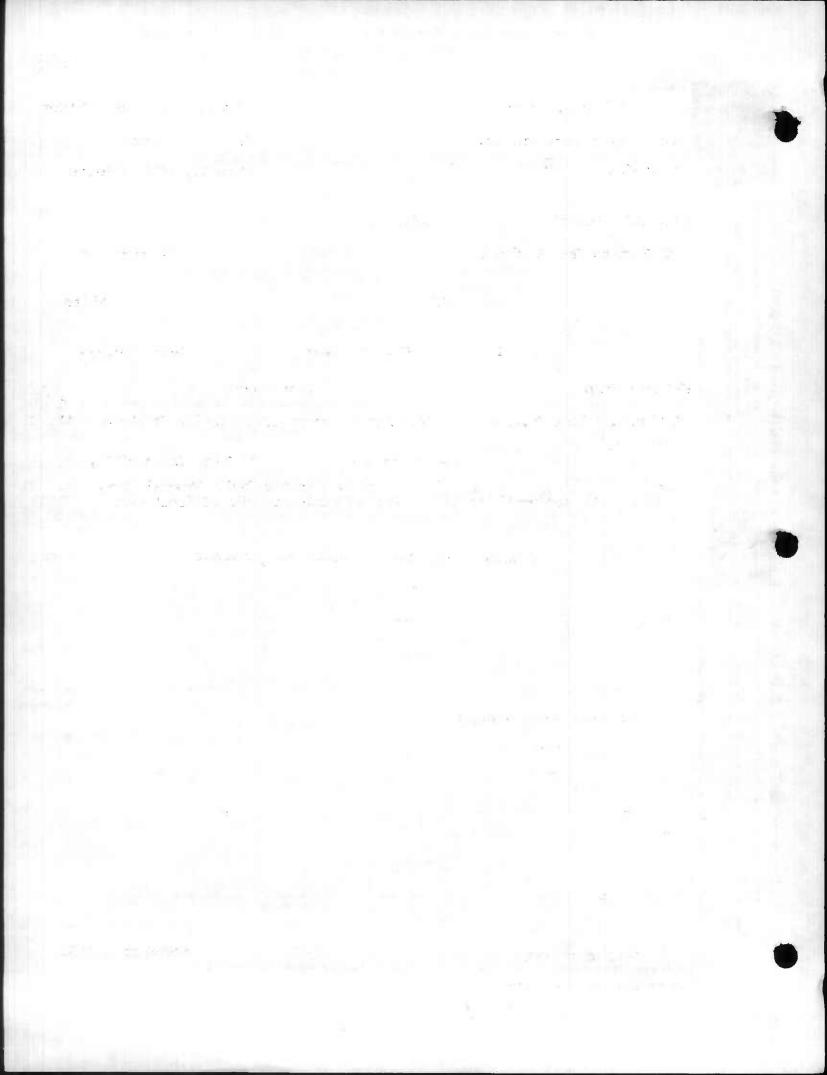
1 ☐ Yas 2 ☒ No

Approximete Intarval Betwaen Onsat and Death

November 2, 1999 30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print) BERNARD P. FARRELL MD

11055 LITTLE PATRIXENT PARKWAY COLUMBIA mD 21044

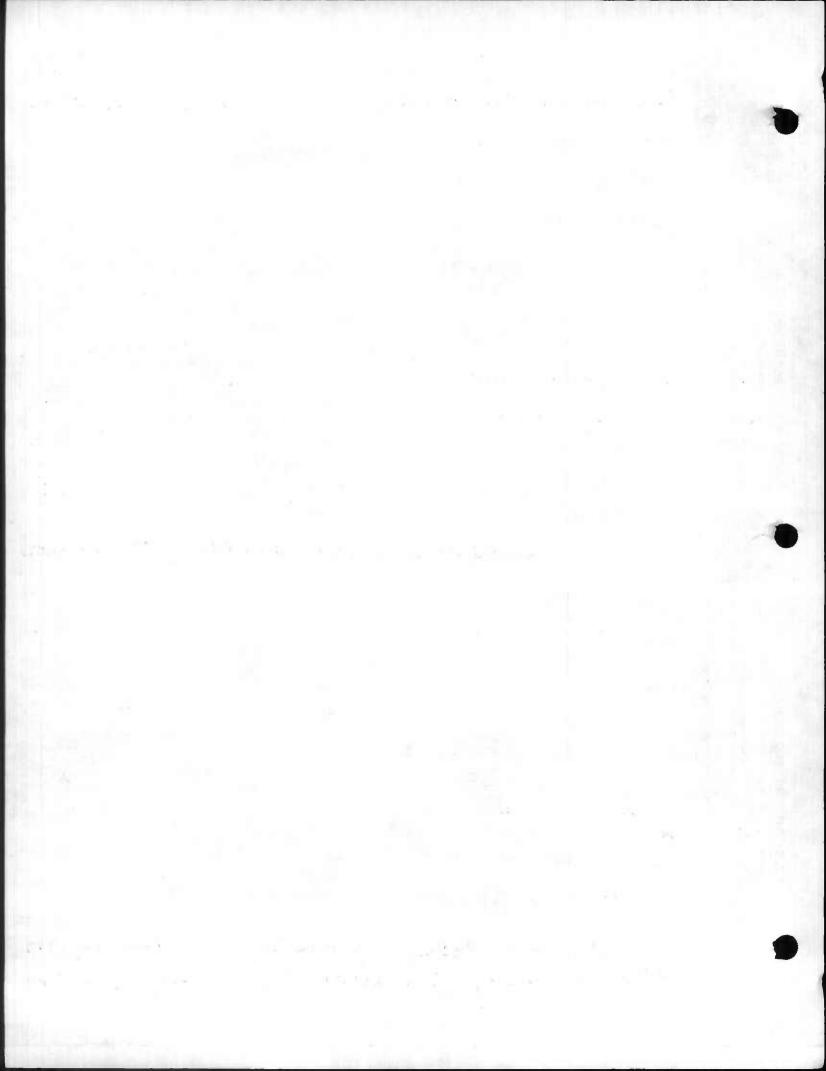
State Registrar 31. Data filed (Month, Day, Year) NOV 0 2 1999 32. Ragistrade Signatura



State of Maryland / Department of Health and Mental Hygiene 36496 Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 8.45 Month Dev HALTER **Physician** awrence 12 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months 10XM 2□ F Yrs 453-47-3133 50 Aug 2, Director 1949 Australia Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yas 2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zio Code 10a. Citizen of Whet Country? permit. Peges 1 end 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Examiner must bings. 8460 Roberts Road 21043 Funeral Australia Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Black, Whita, etc. 11. Maritat Status 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Manager Construction 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Charles Francis Ray Halter Patricia G. Jackson 0 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8460 Roberts Road Ellicott City, Md 21043 Kathleen M. Halter/Wife 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20a Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 10-16-99 Catonsville, MD Metro Crematory 22. Name end Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Undeterwined Primary /Medical Immediate Cause (Finel Site 2 months disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificete be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or es a consequence of): 9 signed by the atte Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 ☐ Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? should Completed page 2 has certificate 1 Yes 2 No or Attending Physician: funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1

Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation 1 Neturel e Hospital or Attending 24 hours efter death. • Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29a. Cartifier completely (Check only one) within 2 \$ 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1 4113 9 May) 12 1999 Knight 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) How and Gen 21044 31. Dete filed (Month, Day, Year) 32. Finglisher's Signeture State 1 5 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item#26per doctor, 11/4/1999 Certificate of Death FCHD, KS 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** :05 BEULAH 26, 1999 VIRGINIA HAMMER October /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHAMPTON MANOR NURSING HOME FREDERICK FREDERICK If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2以F 577-54-2861 Sept 21, 1906 Maryland Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 No Yes 2 No Directo 28e-f Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23a or aminer must be United States

14. Race - American Indian,
Black, White, etc. 404 East 9th Street Funeral 21701 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Yes 2 X No It Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Pages 1 and 2 should be filled w ment of Health and Mental Hygien sant: If Item 27 is marked other th jury or other traumatic event, the Salesperson Appliance Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be To William E. Neil Nettie Virtz 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth N. Bruchey / nephew 404 East 9th Street, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel trom Stete Donetion 5 Other (Specify) Olivet Cemetery 10/29/99 Frederick, Maryland 21. Signatural of Funeral Service Lic 22. Name and Address of Facility
Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, 21702 23a. Part1. Enter the disease, or complications that caused the duals shock, or heert tailure. List only one cause on each line. Approximete Interval Between Onset and Death met enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final ALZHEIMERS DEMENTIA 5 years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): physician s the bunal Box 68760. Physician/Medicai Due to (or es a consequence of): 139 signed by the at d be detached for Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, ò 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: 2 ER/Outpatient 3 DOA Other: 4\sumsing Home 5 \sumsing Residence 6 \subseteq Other (Specify) 1 Yes 2K No Certification: To this. funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No death. e Hospital or Attendi n 24 hours efter death the Funeral Director: A bletely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

completely

within 2 \$

29a. Certifier

(Check only one)

29b. Signeture end title of certifier,

Dr. Richard L. Gough

31. Dete tiled (Month, Dey, Year) OCT 28 1999

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

19 Frederick Street, Walkersville, MD 32. Begistrar's Signature

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

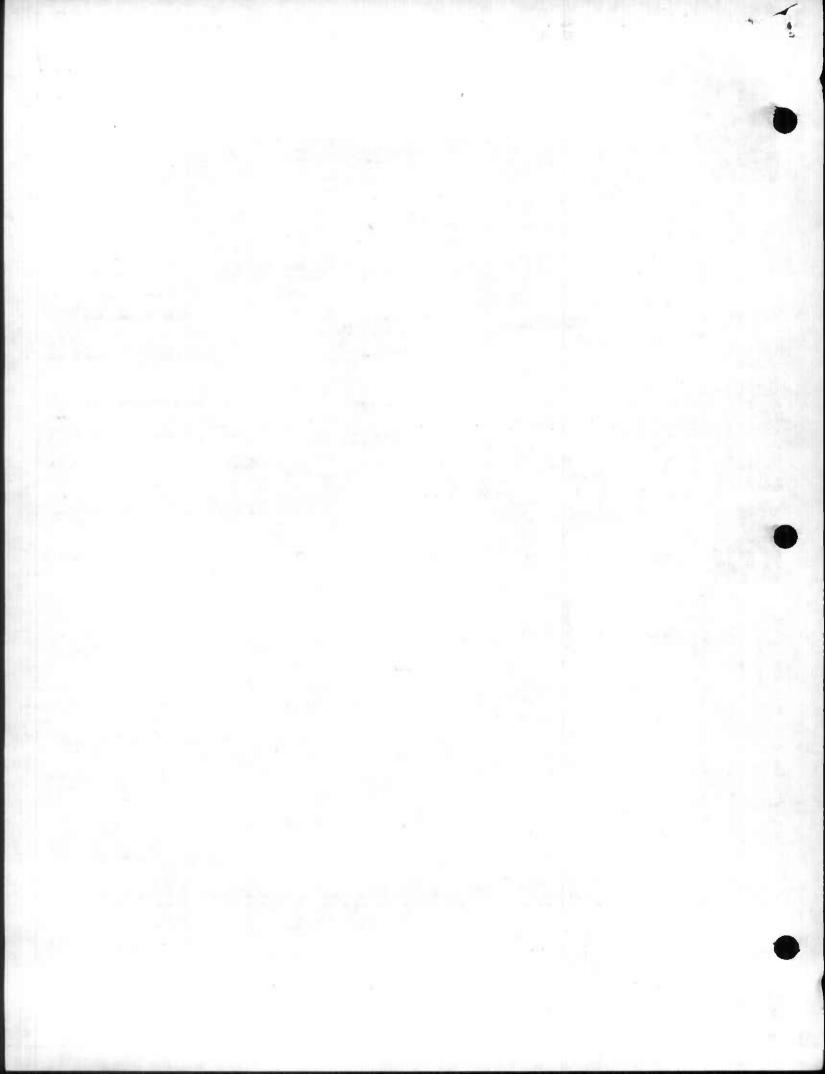
29c. License number

D32171

29d. Date signed (Month, Day, Year)

21793

10/27/99



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Ellen Harris October 29, 1999 3:15 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 28 F 73 Director 220-16-3158 November 25,1925 Maryland Usual Residence of Decedent the Mayland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ahow must be notified at Maryland Frederick Frederick TØ Yes 2 □ No Director 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or heme 23s or 21701 707 East South Street United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after of Hygiene. Other then "natural", or Ne 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Bartender . Pages 1 and 2 should be fliad wi timent of Health and Mental Hyglen tant: if Nem 27 is marked other th jury or other traumatic event, the Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle Last) Be Melvin Nusz Bertha Suter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Mercer/ Daughter 4501 Pine Valley Court, Middletown, Maryland 21769 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 31 Smithsburg, Maryland 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any injury or price. 4 Donation 5 Other (Specify) Smithsburg Crematory 1999 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Keeney and Basford Funeral Home 106 East Church Street Frederick, MD 21701 vuan 23a. Pert1. Entel the disease, or condications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause or much line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Aortic Dissection 2 Days Examiner Due to (or as e consequence of): Examiner Cystic Medical Necrosis 70 Years physicien end s the burief-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 980 ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 900 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of VItal Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA the state 26a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division After 1 X Natural 5 Pending or Attending ster deeth. Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurat Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edical 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es steted.
21 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a D28883 October 29, 1999 ANJUM G. GAZI, MD 30. Name and address of process who completed cause of death (Item 23a) (Type, Print) Anjum G. Qazi, 7600 Carroll Avenue, Takoma Park, Maryland 20912 M.D.

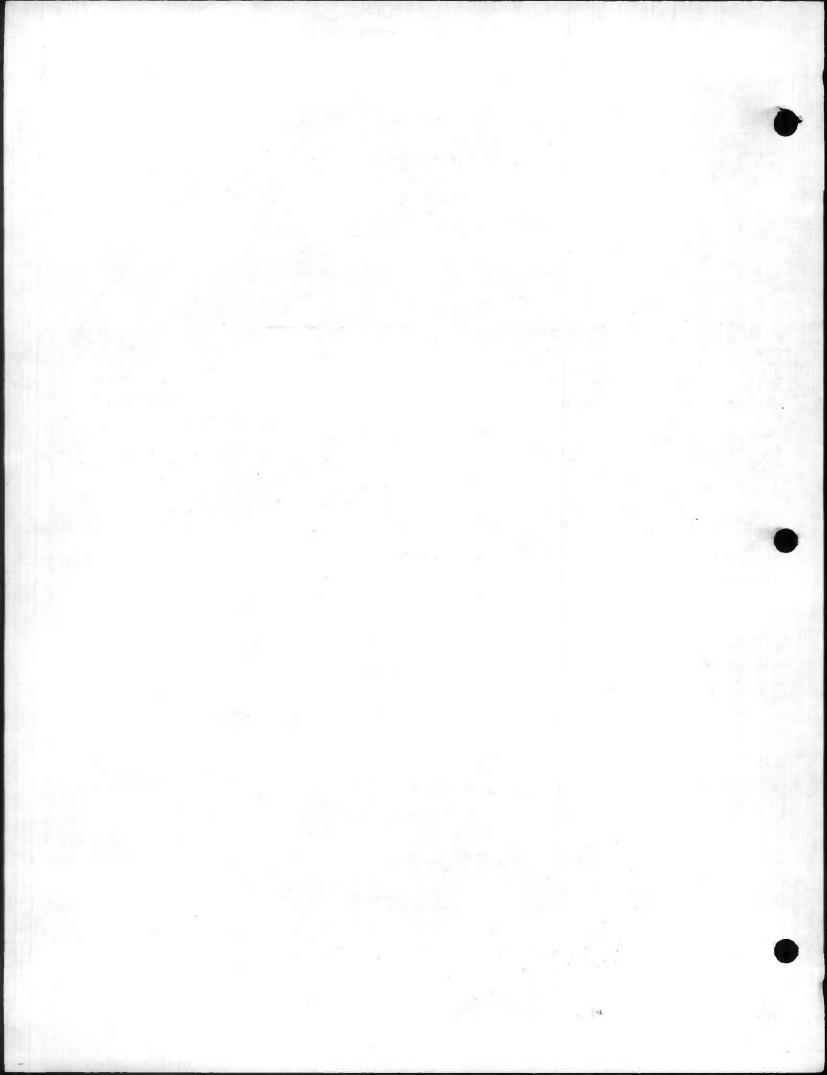
DHMH 16 Rev 6/95

State

Registrar

32. Registrens Signeture

0 8 1999



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

36499 AMEND ITEM 7 11-8-99 HCHD BH Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day NOV **Physician** LEON WINFIELD JUNES 8.27 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MENORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 24 Hrs. Hours Min. If Under 1 Year 9. Birthplace (Stata or Foreign Country)

MARNUAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1/M 20 F Months 218.38.2742 Director NOV. 81,1 Usual Residence of Decedent 11-21-1942 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Show CRACE Ves 2□No HARFORD HAVRE DE MD Funeral Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 151 BLOOMSBURY 21078 45 Hema 12. Was Decedent Ever in U.S. Armed Forces? 1 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Decedent Ever in U.S. 2 Deceden Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 120/6 1 □ Yes 2 2 No 21215-0020 8 Yes Give Yeer or Dates: 2/26/66 Completed by 4 Divorced 3 Widowed BLACK 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. MACHINE OPERATER FACTORI 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marter marked other Maryland 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Neme (First, Middla, Last) Be JONES SR MARGARET CORNIELUS 19e. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 151 BLOOMSBURY AVE HAVREDE GRACE MD 21078 JACKSON ANTOINETTE Baltimore. 20b. Place of Disposition (Nama of cemetary, cramatory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State CENIT. OWINGS MILL, MD APPRISON KOREST 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINERAL HAVEE DE GRACE, MIS 21078 Scar 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): been signed by the atter should be detached for Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? &CINO 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No death 24 hours after deat Punerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) end manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signeture end title of confin 29c. License number 29d. Date signed (Mgnth, Day, Year) 10 M

State Registrar

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NOV 08 **DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COOK BE VOW

State of Maryland / Department of Health and Mental Hygiene

36500

			Certificate of	f Death	Re	eg. No.	2 20200	
Physicia: /Medica		"JOHNSO	N	4b. City, Town, or Loc	2. Date of Death Month OCT	Day 15 1	3. Time of Death Year Q 2: 30 PM	
Examine	4a Facility Name (If not institution, give HOWARD COUNTY	HOW	4c. County of Death HOWARD					
Funeral Director	5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. le	Ast birthday) If Under 1 Yes Months Day		8. Date of Birth (Month, Day, June 9,	Year) 1921	9. Birthplace (State or Foreign Country) Scotland	
the Maryland 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location  Maryland Howard Ellicott City							
€ 8 g	Maryland Howard  10e. Street and Number  2530 McKenzie Roa	đ	10f. Zip Code 210		10	og. Citizen of W Unite	hat Country? ed States	
020 urs efter des	2530 MCKenzie Roa  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spe iban, Mexican, Puerto F o Specify:	cify Yes or No- Rican, etc.)		- American Indian, , White, etc. White	
10 2 3	15. Decedent's Ed (Specify only highest grad	le completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	e during most of working	ng	16b. Kind of Bus	siness/Industry	
d within plan.	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemak			Own	Home	
THE PARTY OF	17. Father's Name (First, Middle, Last)			18. Mother's Name Helen Rol		Aaiden Sumame	)	
CENL	19a. Informant's Name/Relationship (7 Darrell H. Johnso		19b. Mailing Address (Stree 2530 McKenzi					
Saitimore, Remit. Pages 1 and Peptranic of Heelt moortani: if item 27 my injury or other table.	20a. Method of Disposition  12 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ace of Disposition (Name of metery, crematory or other p est Lawn Ceme				city or Town, State	
Baitimo pemit. Page Depertment of Important: If eny injury or ance.	21. Signature of Funeral Service Licens	20 - wil	22. Name and Add Harry H.	ress of Facility Witzke's Facility Columbia Pr	emily Fu	neral F	Home, Inc.	
Physician /Medical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the composition of the composition resulting in death)	SEPTIC Due to (or ASPIRA	SHOCK as a consequence of):	ying, such as cardiac o		981,	Approximate Interval Between Onset and Death  1 DAY  1 WEEK	
K 6876(	Cause (Disease or injury that initiated events resulting in death) Last	. DEME	as a consequence of):				MONTHS	
P.O. net the de deby the deteched	Part II. Other algorificant conditions co	ntributing to death but not result	23b. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown					
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- F 44 (				26. Place of Death	1 ☐ Ye		1 Yes 2 No	
Phy affi	1 □ Yes 20 No		28b. Time of 28c. In	Other: 4 Nursing Hon		nce 6 □Othe		
or Attendent desired or Attendent desired desi	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		M 1	☐ Yes 2☐ No	28f. Location (St City or Town	reet and Numbe n, State)	er or Rural Route Number,	
To the Hospital within 24 hours To the Funeral completely filled		sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death occurred at the on and/or investigation, in my	time, date and place, a r opinion, death occurre	and due to the ca	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)	
To the To the Comp		arkan M!	D D0	053078	(	OCT 1	(Month, Day, Year) 5, 1999	
8	G. WADHAUK	ompleted cause of death (Item AR, MD	23a) (Type, Print) A1	UNAPOUS X	2D#200	ELU!	WIT CITY 21042	
State Registrar	00T 1 a 10	32. Registrar's Signate		de la				

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